

# EXPLAINING RADICAL CHANGE IN GHANAIAAN HEALTH CARE POLICY

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By

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## **Abstract**

The existing literature about the causes of welfare state change, including health care reform, emphasizes stability, yet there is evidence of remarkable changes taking place in welfare systems in much of the developing world. This study analyzes health care reform in Ghana, a country which has experienced significant path-departing changes in just four decades (1957-2003). These changes – the establishment of a National Health Service system with deep (first-dollar) coverage, the introduction of a user-fee system, and the transition to a social health insurance scheme – have been pursued despite key countervailing factors, especially the high political costs associated with them. The study argues that to adequately account for these changes, the policy process should be given special consideration, particularly through the examination of how new policy proposals moved onto the agenda; how they were formulated, adopted, implemented and sustained; and how the reformers managed the entire reform process over time. Based on this analysis, I identified three main interconnected contextual and agential explanatory factors: (a) conjunctural factors, which created windows of opportunity for the changes to occur; (b) policy entrepreneurs, whose leadership, commitment and strategies helped in taking advantage of these opportunities to propel, sponsor, design, adopt, implement and sustain the policy changes; and (c) the concentrated institutional configuration of Ghana, which limited the number and scope of the veto points available to interest groups opposed to the proposed changes. While these three factors contributed to why and how the changes occurred, I identified policy entrepreneurs' commitment, leadership and strategies, including the feedback effects of those strategies, as the most crucial factors. The study contributes to existing health policy literature by showing how perspectives such as the window of opportunity thesis, the dynamic political process model, the historical institutionalist approach to radical policy change and, finally, the ideational scholarship on framing processes can be combined to enrich our understanding of radical policy change. The study also introduces

additional mechanisms of policy change that involve the use of repressive strategies before suggesting some modifications to a number of widely-shared assumptions within the welfare state literature focusing on path dependency, globalization, partisan ideology and vested interests.

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*“A grateful mind is a great mind which eventually attracts to itself great things.”*

Plato

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### **List of Abbreviations**

CBHISes	Community-Based Health Insurance Schemes
CDU-CSU	Christian Democratic Union-Christian Social Union
CEO	Chief Executive Officer
CHAG	Christian Health Association of Ghana
CPP	Convention Peoples Party
CVC	Citizen Vetting Committee
DANIDA	Danish Development Assistance Programmes
DMHIS	District Mutual Health Insurance Scheme
GDP	Gross Domestic Product
GHS	Ghana Health Service
GMA	Ghana Medical Association
GNEMHO	Ghana Network of Mutual Health Organisation
GPRTU	Ghana Private Road Transport Union
GSS	Ghana Statistical Service
HIPC(s)	Highly Indebted Poor Country(ies)
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ILO	International Labour Organisation
IMF	International Monetary Fund
KNRG	Kwame Nkrumah Revolutionary Guards
LECIAD	Legon Centre for International Affairs and Diplomacy
LI	Legislative Instrument
LICs	Low-Income Countries
MDGs	Millennium Development Goals
MHOs	Mutual Health Organisations
MoH	Ministry of Health
NDC	National Democratic Congress
NDM	New Democratic Movement
NGOs	Non-Governmental Organisations
NHIA	National Health Insurance Authority
NHIC	National Health Insurance Council
NHIF	National Health Insurance Fund
NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme
NHS	National Health Service
NIC	National Investigations Committee

NLC	National Liberation Council
NPM	New Public Management
NPP	New Patriotic Party
NRC	National Redemption Council
NUGS	National Union of Ghana Students
OECD	Organisation of Economic Corporation and Development
PNDC	Provisional National Defence Council
NDC	National Democratic Congress
PAMSCAD	Programme of Action to Mitigate the Social Cost of Adjustment
PCHIS	Private Commercial Health Insurance Scheme
PMHIS	Private Mutual Health Insurance Scheme
PNDC	Provisional National Defence Council
PNP	People National Party
PP	Progress Party
PSoG	Pharmaceutical Society of Ghana
SAERP	Structural Adjustment and Economic Recovery Program
SAPs	Structural Adjustment Programs
SEND-GH	Social Enterprise Development-Ghana
SHI	Social Health Insurance
SMC	Supreme Military Council
SPD	Social Democratic Party
SSA	Sub-Saharan Africa
TUC	Trade Union Congress
UK	United Kingdom
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's and Emergency Fund (now known simply as, United Nations Children's Fund)
US	United States
VAT	Value Added Tax
WDC	Workers Defence Council
WHO	World Health Organization

## **Glossary**

### ***Key Concept***

### ***Definition***

<b>Asset Specificity</b>	The tendency for a person to be tied to a particular duty or function as a result of his/her training type or long experience in performing such task.
<b>Conjunctures</b>	A combination of conditions that make change essential, e.g., crisis
<b>Policy Drift</b>	A change in the effects of a given policy as a result of a change in the environment in which the policy operates, combined with the absence of measures to adapt this policy the new context.
<b>Framing</b>	A systematic use of words or arguments to influence social behaviour, including policy actions.
<b>Globalization</b>	A process of growing interaction or integration among nations.
<b>Ideas</b>	Meanings, worldviews, assumptions, beliefs and norms shared by actors.
<b>Institution</b>	Formal and informal rules, procedures and principles that impact human behaviour.
<b>Institutional Friction</b>	The constraining mechanisms created by an institution.
<b>Layering</b>	The process of grafting new policy elements onto an established arrangement in order to change its trajectory over time.
<b>Partisanship</b>	The practice of upholding the interest of a particular political party over all other interests in the day to day affairs of a country.
<b>Party discipline</b>	The constitutional principle that allows parliamentarians from the same political party to be compelled to vote in the same line on a given issue.
<b>Path Dependency</b>	The perspective that past policy decisions shape new policies, resulting in relative stability over time.
<b>Policy</b>	A chosen course of action by government in a given situation.
<b>Policy Change</b>	The modification or replacement of an existing policy.
<b>Policy Entrepreneurs</b>	The core agents or proponents of a policy change, as signified by their choices, commitment and strategic leadership.
<b>Policy Legacy</b>	The enduring effect of past policy decisions.
<b>Positive Feedback</b>	A positive outcome of an undertaking, which could incite one to continue on the same path or sustain the status quo.

<b>Punctuated Equilibrium</b>	Stable institutional arrangements which are interrupted by sudden and dramatic changes, which only occurs on rare occasions.
<b>Repression</b>	The use of physical force or threat to influence human behaviour.
<b>Social Policy</b>	Policy actions geared towards enhancing wellbeing and promoting economic security.
<b>Strategic Choice</b>	A tactical course of action in a given situation.
<b>Translation</b>	The process of adapting foreign models to suit local contexts.
<b>Unitary State</b>	A state that is run by a single supreme authority. All powers exercised by the sub-units within this state are delegated by the supreme authority.
<b>Welfare State</b>	The social policies and programs of a state.
<b>Window of Opportunity</b>	A rare and typically short moment favourable to the advent of policy change.
<b>Vested Interests</b>	Individuals or groups that benefit from the status quo.
<b>Veto points</b>	The institutionalized opportunities to block policy change within a given polity or institution.

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# CHAPTER ONE

## INTRODUCTION

### 1.1 Introduction

The spate of health care reforms across the globe since the 1980s has inspired numerous studies on the causes of health care policy change and stability. These studies have yielded several theoretical models and concepts that seek to explain how change occurs. Despite the growth in the health care literature on policy change, more work is needed to understand how and why health policy change actually occurs (Starke, 2010; Béland, 2010). One reason many scholars appear to agree that additional research is required is that most existing literature about policy change focuses primarily on stability rather than change (Béland & Hacker, 2004; Béland, 2010; Brown, 2010; Feder-Bubis & Chinitz, 2010; Hassenteufel, Smyrl, Genieys, & Moreno-Fuentes, 2010; Sitek, 2010; Starke, 2010).

In his widely cited article, Pierson (1996) introduced the “new politics of the welfare state” approach. Here, Pierson (1996) argued that the unpopularity of and high political costs associated with radical reform makes the welfare state, including health care, “far more resilient than other key components of national political economies and far more durable than existing theories of the welfare state would lead one to expect”(Pierson, 1996, p. 144). In *Politics and Time*, Pierson (2004) introduced what he referred to as “reproduction mechanisms”. Defining reproduction mechanisms in relation to coordination problems, veto points, asset specificity and positive feedback, he argued that they are as crucial in explaining policy stability as they are in explaining change. However, as claimed by Béland (2010, p. 620), “his book focuses on self-reinforcing mechanisms rather than change”.

Another key factor is that many researchers who study policy change fail to conduct their studies in ways that explain policy change, rather than simply describing it. Béland (2010) argues that, to enhance the explanatory power of their studies, scholars must incorporate ideas

into their analytical frameworks. Ideational analysis would enable scholars to properly define what they mean by policy change; how the idea of change emerged, as well as how solutions were devised, designed, championed, implemented and sustained over time. Starke (2010), in turn, emphasizes that, since policy change may not be caused by a single factor, scholars should be able to show how various causal factors interact to shape policy change.

Yet aside from the inadequate attention paid to, and the theorizing of, policy change, many theories and models formulated in existing health care studies are both quite diverse and relatively recent. This creates opportunities to empirically assess the adequacy of these theories and models in explaining policy change in health care, especially path-departing change, which is the focus of this dissertation. This study is based on the premise that extending the focus beyond developed countries will advance the understanding of policy change in health care both empirically and theoretically. Currently, the policy change literature is skewed towards the developed world, especially towards members of the Organization for Economic Co-operation and Development (OECD). This focus is paradoxical because health care change, on average, is taking place at a faster pace in developing and less-developed countries than in OECD member countries. Thus, significant health policy change, including radical change, is ever present in the developing world. This mismatch between the “OECD-centric” nature of the literature on policy change in health care and the constant burst of activity witnessed in the Low-Income Countries (LICs) limits the ability to explain change, both empirically and theoretically.

Since both health care system and policy change are context-dependent, extending the focus from the developed world to LICs can strengthen existing explanatory frameworks dealing with health policy change and stability (Collins, Green & Hunter, 1999). It may also serve as a good context in which to test, as well as to enrich, the general literature on health policy change. Additionally, given that LICs face severe human resource and health care

challenges, studying policy changes in those countries yields findings that health policymakers and stakeholders in those regions may find useful. For instance, such research may help them to better shape the process of health policymaking in order to improve its effectiveness (Walt & Gilson, 1994; Grindle, 2000). Finally, studies about health care reform in the developing world would go a long way toward enhancing the international community's potential for reaching the health-based Millennium Development Goals (MDGs) set by the United Nations in 2000 (Buse, Booth & Harmer, 2008). These goals include reducing child mortality, particularly the under-five mortality rate, by two-thirds; improving maternal health with a focus on reducing maternal mortality by three-quarters; and combating HIV/AIDS, malaria, and other diseases. All of these goals are to be achieved by 2015 (Nayyar, 2012). However, recent evaluative studies about the MDGs show that many LICs are unlikely to meet the targets, particularly those related to maternal and under-five mortality (Easterly, 2009; Bello & Suleman, 2011; Bhattacharya, Khan, Salma & Uddin, 2013),

In order to address the limitations of the health care literature outlined above, this study analyses radical changes in Ghanaian health policy with a particular emphasis on the three major health system reforms the country has pursued since attaining political independence in 1957. As illustrated in Table 1, these major, path-departing changes involve the establishment of a National Health Service (NHS)-style system with deep (first-dollar) coverage in the 1950s/1960s, the introduction of an extensive user-fee system in 1983/1985, and the shift away from user fees to the introduction of a social health insurance (SHI) system, officially referred to as the National Health Insurance Scheme (NHIS), in 2003/2005.

There are excellent reasons to focus on the Ghanaian case in the context of the debate about policy change in health care. The most fundamental reason is the fact that studying health care changes in Ghana addresses the main problems identified in the mainstream literature on policy change: the inadequate attention to path-departing policy change and the lack of focus



on the developing world. Generally touted as a “beacon of Africa” (World Bank, 1993, p. ix), Ghana is a good starting point for understanding policy change in LICs, particularly in Sub-Saharan Africa (SSA), which is the least developed continent in the world. In addition, Ghana provides an appropriate medium for probing further into other factors that may explain health policy change, such as political ideology, globalization, and path-dependency. The study's findings would, therefore, be a crucial source of information and a capacity building tool for health care scholars, policy makers and other stakeholders in Ghana and elsewhere in SSA to better grasp, and perhaps shape, the process of health policymaking to improve health outcomes (UNDP-Ghana & NDPC/GOG, 2012; Commonwealth Foundation, 2013).

Table 1 Ghana's three regimes of health care policy

CRITERIA	NHS (1957-1982)	USER-FEE (1983/5-2003)	SHI (2003-present)
Mode of Payment	<b>Public revenue</b> (free at point of delivery)	<ul style="list-style-type: none"> <li>✓ <b>Public revenue</b></li> <li>✓ Out-of-pocket payment at point of delivery</li> </ul> <p>Exempted groups (supposed)</p> <ul style="list-style-type: none"> <li>▪ Indigents</li> <li>▪ Pregnant women</li> <li>▪ Babies</li> <li>▪ Health workers</li> </ul>	<p><b>National Health Insurance Fund</b></p> <ul style="list-style-type: none"> <li>✓ Public (grants, investment, budget, NHIS levy)</li> <li>✓ Contribution <ul style="list-style-type: none"> <li>□ Formal workers (2.5% SSNIT)</li> <li>□ Informal workers (premium)</li> </ul> </li> </ul> <p>Exempted groups</p> <ul style="list-style-type: none"> <li>▪ Indigents</li> <li>▪ Pensioners &amp; dependents</li> <li>▪ Pregnant women</li> <li>▪ Children (under 18)</li> </ul>
Spending levels	<b>Public (100%)</b>	<p><b>Public (40%)</b> <b>Private (60%)</b></p> <p><b>User fees (15% of MoH budget &amp; 80% of hospital non-salary expenditure)</b></p>	<p><b>Public (60%)</b> <b>Private (40%)</b></p> <p><b>National Health Insurance Fund</b> (16% and 30-41% of total and public health expenditure respectively)</p>
Services	<b>Universal</b>	<p><b>-All</b> (e.g. consultation, laboratory, medical, surgery, dental, medical examination, hospital accommodation, drugs) <b>except those with exemptions</b></p> <p><b>Exempted services (supposed)</b></p> <p>Treatment of tuberculosis, leprosy, psychiatric, immunization, antenatal and postnatal, treatment at child welfare clinics</p>	<p><b>Basic Benefit Package (BBP)</b> (E.g. Outpatient Services, Inpatient Services, Oral Health, Maternity Care, Emergencies etc.)</p> <p><b>Exempted services</b></p> <p>Appliance and prostheses Cosmetic surgeries, Assisted Reproduction, Echocardiography, Photography and Angiography, Dialysis for chronic renal failure, Organ transplantation, All drugs not listed on the NHIS list, Heart and brain surgery other than those resulting from accidents, Cancer treatment other than breast and cervical, Mortuary Services, Diagnosis and treatment abroad, Medical examinations for purposes other than treatment in accredited health facilities (e.g. Visa application, Educational, Institutional, Driving licence, etc.), VIP ward (accommodation)</p>

Delivery	Government and religious organizations own, provide and paid almost all services through the Ministry of Health (MoH) and Religious-based providers (RBP) respectively	Government own and provide health service, but the public pay for use of service  Private provision is earnestly encouraged, while user fee is increased significantly at implementation level  With the encouragement of private provision, the government (MoH & NHS) lost its supremacy in overall health service provision to the private sector (RBP & FPPP)	The responsibility to purchase health care on behalf of the public was taken away from the MoH to the newly created National Health Insurance Authority (NHIA)  Hence, the NHIA contract accredited providers (public & private) and pay them for their services  MoH - policymaking for the health sector. NHIA - purchaser of health services. NHS - public service providers RBP- non-profit private providers FPPP - For-profit private providers
Population Coverage	<b>Universal</b>	<b>Exempted group, but</b> exemptions were usually not implemented by providers Hence, 51-56% of the sick ceded it	<b>Universal coverage is the goal</b> , but as at 2012, active membership hovered around 35% of Ghana's population, while cumulative membership hovered around 70% by 2011

## 1.2. Overview of Health Policy Change and Stability in Ghana

As Table 1 demonstrates, Ghana's health care system, like that of many other former British colonies in SSA, operated as a British-style NHS until the 1980s. The Ghanaian NHS consisted of government-owned health care facilities, including hospitals, clinics and health centres, whose activities were entirely financed through general tax revenue. All NHS employees, including doctors, nurses, health service administrators, accountants and pharmacists worked (and still do work) directly for the state, providing tax financed health care services to citizens as a matter of right. Although some private health care institutions (mostly mission hospitals) also operated in Ghana prior to 1980, the government owned and operated NHS provided most of the health care services in the country.

With the economy deteriorating from the late 1960s, general state tax revenues were insufficient to sustain this system (Agyepong & Adjei, 2008). Hence, user (dispensary) fees were introduced in 1969 to complement the fiscal efforts of the state (SEND-GH, 2010), but were immediately withdrawn due to massive public protests (SEND-GH, 2010). During the oil crisis and in the face of high drug costs in the 1970s, the government was compelled to reintroduce the user fee policy (SEND-GH, 2010). Nevertheless, this reform also failed to reach the implementation stage, as the government was toppled in a coup d'état as a consequence of

the poor state of the Ghanaian economy in general, and including the health sector<sup>1</sup> (Baidoo, 2009; Wahab, 2008). After that, as Coleman (2011) notes, user fees did not reappear on the policy agenda until the 1980s, when the country adopted the World Bank and the International Monetary Fund's (IMF) Structural Adjustment and Economic Recovery Programme (SAERP).

The SAERP was meant to resuscitate the Ghanaian economy after the 1980s global recession and, allegedly, to protect the basic needs of the people (Frimpong, 1997; Aryeetey & Harrigan, 2000; Baidoo, 2009; Ohemeng & Ayee, 2012). Under this programme, the NHS was restructured and the private sector was encouraged to actively complement state efforts in health service provision. The government, led by the Provisional National Defence Council (PNDC), also reduced its spending levels, which strongly affected the health sector. As a consequence, the user fee policy, popularly referred to as “cash-and-carry”<sup>2</sup> in Ghana, was reintroduced to generate additional revenues to support the health sector. However, the user fees led to significant underutilization of the health care system, as it was unaffordable for many people. Oppong (2001) reports that due to inadequate funding, some of the public health care facilities closed down, while many others had to operate without adequate resources (cited in Baidoo, 2009). In view of the plight facing the health care system, various stakeholders (e.g., communities, the government and several international stakeholders in the health sector) began to explore alternative means of health care financing and delivery, including different types of health insurance policy. However, most of these alternatives failed because of poor leadership and a lack of consensus and direction (Agyepong & Adjei, 2008).

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<sup>1</sup> A modicum of nominal fees was introduced, but its purpose was to eliminate frivolous use rather than to generate revenue.

<sup>2</sup>“Cash-and-carry” was initially coined to describe the situation whereby healthcare providers were required to make cash payment before receiving drugs from the National Medical Stores. In turn, the service providers demanded cash payment before delivering services to the public. Thus, overtime, the policy became publicly known as Cash-and-Carry, which is currently more popular than its actual name -user fees or cost recovery.

In 2001, the newly elected New Patriotic Party (NPP) government took the final decision to remove the financial barrier to health care accessibility in Ghana. The decision resulted in the enactment of the National Health Insurance Scheme (NHIS) Act in 2003 which was implemented in 2005 and amended in 2012. The NHIS is a social insurance system, managed independently by the National Health Insurance Authority (NHIA) and financed through the National Health Insurance Fund (NHIF). Its main goal is to replace the cash-and-carry system. Under the NHIS, approved private and public health care providers are usually reimbursed for services provided to members of the scheme<sup>3</sup>. The impact of the NHIS on health care accessibility is largely reported and believed to be positive (Dixon, 2011), but others have crucial reservations, leading to series of proposals for reform (Baidoo, 2009; Apoya & Marriott, 2011; Moszynski, 2011). In the 2008 elections, for example, the social democratic National Democratic Congress (NDC) promised to transform the system into a “one-time premium” policy; since assuming office in January 2009, it has yet to fulfil this promise.

### **1.3. Problem Statement**

As indicated above, the literature on changes in the welfare state, including health care reform, focuses largely on institutions<sup>4</sup>, particularly path-dependency<sup>5</sup> (Pierson, 1996). This tendency has created the broad assumption that radical changes in welfare systems, including health care policies, are unlikely to succeed even when perceived economic and political windows of opportunity emerge. As the discussion above suggests, however, since independence Ghana has transitioned across all the world’s three major health care policy regimes (National Health

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<sup>3</sup> In 2012, the capitation system of paying service providers was explored and piloted in the Ashanti Region, but it faced a high levels of resistance from providers. Consequently, its implementation countrywide remains limited.

<sup>4</sup> Formal and informal rules and customs and how they constrain or facilitate ability to cause policy change.

<sup>5</sup>The contention that past policies significantly shape later policies so that policy change tends to retain much semblance with the past rather than being a significant departure from it.

Service, User Fees, and Social Health Insurance) Schmid et al. (2010) identified. This situation suggests that path departing policy change in health care might be more prevalent than what existing institutionalist theories claim.

Second, the Ghanaian reforms have occurred within just four decades of independence (1957-2003). Although policy scholars have yet to specify the precise timeframe within which radical policy changes tend to occur, the literature on radical policy change inspired by historical institutionalism, particularly the punctuated equilibrium<sup>6</sup> approach (Jones & Baumgartner, 2005), suggests significantly longer periods of institutional stasis before radical policy change could occur. Empirical experiences in countries such as the US, Switzerland, Britain, Sweden, Germany, Canada and Israel, among others, also reinforce the above assumption, suggesting that the three broad health care policy changes that took place in Ghana in these four decades occurred during an unusually short period of time. For instance, since the creation of Medicare and Medicaid in the United States in the 1960s, all efforts to radically transform the US system into a national health insurance system have failed (Feder-Bubis & Chinitz, 2010). Since its establishment in the 1950s and 1960s, Canada's health care system has also remained largely the same (Bhatia & Coleman, 2003). The same remark applies to Israel, where its 1995 national health insurance legislation is said to have taken over 45 years of debates to pass (Feder-Bubis & Chinitz, 2010). Even in Britain, Sweden and Germany, where economic and fiscal pressures led to important social policy changes, the magnitude of these changes, according to Pierson (1996), was limited rather than radical<sup>7</sup>.

Finally, these reforms succeeded despite the presence of countervailing forces, vis-à-vis opposition from vested interests and, at times, ideological conflict and hostility from powerful actors in the global system, including the World Bank and the International Monetary

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<sup>6</sup> The perspective that once in a blue moon, a long period of policy stability or stasis is upset by an abrupt event or conjuncture, leading to policy reversal or path-departing change.

<sup>7</sup> This argument, however, has been challenged by more recent social policy scholarship (see Gilbert, 2002; Hacker, 2004).

Fund (IMF). As well, in spite of the failure to implement the NHS in the colonial period, after independence, (Arhinful, 2003), politicians sought to implement this model despite resistance from the vested interests that orchestrated the said failure (Coleman, 1999). Beyond resistance from vested interests, including labour groups, the general public<sup>8</sup> and the military<sup>9</sup>, the user fee policy was also pursued even though it conflicted with the ideological orientation of the PNDC government that introduced it<sup>10</sup> (Møgedal, Steen & Mpelumbe, 1995; McIntyre, Gilson & Mutyambizi, 2008; Baidoo, 2009). In addition to opposition from vested interests<sup>11</sup> and being counter to the ideology of the government<sup>12</sup>, the NHIS reform was also pursued at a time when Ghana was a Highly Indebted Poor Country (HIPC), which would make it financially difficult to sustain the policy. What appeared even more startling with respect to the NHIS is that it was pursued against the wishes of key foreign donors, including the World Bank and the IMF, who have been frequently depicted in the global social policy literature as the prime movers of radical reforms in the developing world (Batley, 1995; Cassels, 1995; Neuman, 1998; Grindle, 2000; Clapp & Swanston, 2009; McCarthy-Jones & Turner, 2011). Tackling these puzzles present interesting opportunities to further advance the ongoing debate on health care policy change, in SSA and elsewhere around the world.

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<sup>8</sup> Whereas constituencies opposed to user fees were successful at preventing their implementation in the late 1960s and the 1970s (Coleman, 2011), they were not successful in the 1980s.

<sup>9</sup> Also, given that almost all previous attempts to introduce similar policies had resulted in coups d'état (Coleman, 1997; Wahab, 2008; Baidoo, 2009), such a reform should have been “unthinkable”.

<sup>10</sup> In particular, many Ghanaians were also perplexed by the user fee policy, because the government that introduced it was on the left of the political spectrum, and would have thus been expected to oppose user fees.

<sup>11</sup> It was also pursued in the face of and resistance from well mobilized domestic interests such as the Trade Union Congress (TUC) and the Ghana Network of Mutual Health Organizations (GNEMHO), among others (Coleman, 2011).

<sup>12</sup> While leaning towards the left of the ideological divide, the NHIS was introduced by the NPP government, which was on the right of the ideological and political spectrum.

## **1.4. Purpose/Objective and Research Questions**

### **1.4.1. Purpose**

This dissertation focuses on Ghana and seeks to explain why and how the country could achieve these path-departing changes in health care policy in such an unusually short timeframe, despite the countervailing forces mentioned above. In the process, the study also pays particular attention to the magnitude of the changes, the causal factors underlying them and the mechanisms through which the various causal factors interacted to produce these changes within the said timeframe.

### **1.4.2. Research Questions**

This dissertation explores five key questions:

- a) What makes Ghana's transition from the NHS-type model of health care to user fees and the shift away from user fees and the advent of social insurance significant?
- b) What factors made the shift from the colonial system of health care to the NHS-type model in the 1960s, the shift away to user fees in the 1980s and finally the advent of social insurance in the 2000s possible?
- c) How did the various causal factors interact to produce such successive policy changes at specific moments in time?
- d) Why were the policy changes (the user fee and the NHIS in particular) successful, despite the evidence of clear countervailing forces such as vested interests, financial setbacks, ideological conflicts and political risks?
- e) What made those changes possible within the relatively short timeframe in which they occurred?

#### *1.4.2.1. Rationale and Explanation of Research Questions*

When studying policy change, it is crucial to first examine what exactly changed before trying to explain it (Campbell, 2004). For instance, Cacace and Frisina (2010) note that “though we recognize the need to move away from mere description if we want to achieve explanation, sound description must not be missed: the dependent variable, health care system change, needs clear specification before the roots of this empirical phenomenon can be identified” (p. 450). Beyond enabling us to understand what exactly changed, specifying the dependent variable also enables us to ascertain the magnitude and significance of the change involved. A better way to achieve this, as indicated by scholars such as Pierson (1996), Esping-Andersen (1990) and O’Connor (2002), is to go beyond the common emphasis in the institutionalist literature on quantitative or spending changes to explore, most importantly, qualitative and institutional factors such as change in benefits (comprehensive vs. targeted), change in allocation responsibility (government vs. private sector) and shifts in eligibility criteria (universal vs. targeting and means-testing). As Esping-Andersen (1990) notes, focusing on spending could be “misleading”, as “expenditures are epiphenomenal to the theoretical substance of welfare states” (Esping-Andersen, 1990, p. 19). Rather, scholars should focus on “de-commodification”, which measures the extent to which social policies enable individuals to obtain benefits on the basis of citizenship rather than on the basis of charity, merit, conditionality or market forces (Esping-Andersen, 1999, p. 22). Thus, as O’Connor (1998) notes, “de-commodification is central to the welfare state project” (p. 158). Question (a) was, therefore, posed to enable this study to address the above limitations in the literature.

Additionally, health policy change is caused by both political and technocratic factors (Parsons 1995; Fischer 2003). The technocratic factors involve the role of expertise, appropriate policy content, research evidence, adequate finance, technical advice and methods of administration. The political factors, on the other hand, include the broad historical, social,



cultural, economic and institutional contexts within which reforms are carried out, and the number of actors (e.g., formal and informal, internal and external) who have an interest in the reform, as well as the processes (agenda setting, formulation, implementation and evaluation) through which these reforms are carried out. Although most studies about the causes of health care system change and stability in SSA often neglect the political factors, they are the most relevant for analysing both health policy change and stability in the region (Walt & Gilson, 1994; Gilson et al, 2003; Agyepong & Adjei, 2008; Buse & Booth, 2008; Gilson & Raphaely, 2008; Hercot, Meessen, Ridde & Gilson, 2011; Meesen et al., 2011). In addressing the above gap in the literature, question (b) takes interest in both the political and the technocratic factors underpinning the reforms. For example, this question allows this study to examine the reform process to ascertain how the various causal and contextual factors manifested themselves over time, from agenda setting to formulation, legislation and implementation, and identify the key actors involved in the reform process and the roles they played. It also forces us to examine the extent to which technocratic factors influenced the reforms the way they did.

Question (c), on the other hand, asks how exactly various causal factors interacted to produce policy change at a specific point in time. This is also important because several scholars have observed that one-dimensional explanations are typically problematic in offering a comprehensive or full account of health policy change (Collins et al, 1999; Kingdon, 2003; Parsons, 2007; Béland, 2010; Starke, 2010). Starke (2010) argues that health policy scholars should explore how various causal factors interact in order to strengthen their explanatory power. Question (c), therefore, allows the study to draw ideas from the qualitative literature on causal and interactive mechanisms (for example, Hall, 1993; Collins et al., 1999; Kingdon, 2003; Campbell, 2004; Parsons, 2007; Weyland, 2008; Béland, 2010; Starke, 2010) to establish a framework that explains how the radical health policy changes occurred in Ghana.

In questions (d) and (e), the occurrence of radical policy changes are further explored to ascertain whether any of the existing analytical perspectives on policy change, such as institutionalism, globalization, functionalism and partisan politics and ideology, fits with the observations made in the case of Ghanaian health policy. This point is also significant because it helps to ascertain the strengths and weaknesses of these existing perspectives, and it suggests ways to rethink some of their fundamental underpinnings. The fundamental difference between questions (d) and (e) is that the latter focuses on why the changes occurred within the relatively short timeframe in which they occurred, while the former emphasizes the partisan politics approach and reminds us of how these changes took place despite the presence of countervailing factors, especially the high political costs associated with such changes.

### **1.5. Main Argument of the Study**

Based on analysis of the data for this study, none of the mainstream perspectives on policy change mentioned above (and explained in detail in the next chapter) is found to adequately explain the radical health system shifts in post-independence Ghana. Rather, to account for these changes, one must pay particular attention to the policy process and, particularly, to how certain contextual and agential factors interacted. The fundamental factors identified as critically important include (a) the role of conjunctural factors in creating windows of opportunity for the changes; (b) policy entrepreneurship by key policy actors that propelled the changes onto the agenda, instituted and sustained them over time; and (c) the concentrated institutional configurations of the Ghanaian state, which minimized the veto point for interest to oppose all the changes as well as facilitated the goal of the reformers, at least at the adoption stages.

First, conjunctural factors such as the state of the Ghanaian economy, the position or crisis of the health system, and changes in government interacted at the beginning of each phase

of the health policy process to create the urgency for change or windows of opportunity for the changes. The establishment of the NHS system, for instance, resulted from the window of opportunity created by the economic boom of the late 1950s/early 1960s, combined with three other factors: political independence and attaining republican status around the same time: the election of a socialist and nationalist leader, Dr. Kwame Nkrumah; and the global trend towards welfare state expansion. The user fee model had its roots in the economic bust of the 1980s and its adverse effects on the fiscal situation of the health care sector. Aggravating factors included the political transition (from the Limann PNP constitutional government to the Rawlings PNDC military regime in 1981/2), the failure of the earlier populist measures of the PNDC government, the 1983 expulsion of Ghanaian emigrants in Nigeria and, finally, the failure of efforts to solicit help from the Eastern Bloc. In turn, the introduction of the NHIS was precipitated by the crisis of the user fee model, coupled with the change in government in 2001 and, particularly, the election of the Kufour NPP government, which had campaigned on the promise of abolishing the user fee system.

Second, key policy entrepreneurs took advantage of these windows of opportunity and then instituted and jealously guarded the changes. Six kinds of policy entrepreneurs were identified in this respect. The first group of entrepreneurs encompassed those actors who propelled the policy changes onto the agenda of the governments in power. They were made up of officials of the Maude Commission of enquiry during the transition to the NHS system; the Ghana Medical Association (GMA), the Pharmaceutical Society of Ghana (PSoG), the Ministry of Health (MoH), and the World Bank and the IMF, during the introduction of the user fee model; and the MoH and the Community-based Health Insurance Schemes (CBHISes), during the establishment of the NHIS.

After making it onto the agenda, the policy changes had to be designed, adopted, implemented and sustained. Doing so, however, involved difficulties. For instance, vested

interests, partisan actors and, in the case of the NHIS, powerful international agencies resisted the changes. Sailing through those obstacles required additional policy entrepreneurship by the governments in power, among others. The governments in power are the second category of policy entrepreneurs. They acted as sponsors, leaders, supervisors or coordinators of the entire reform processes. The extent to which they were committed to the reforms and the strategic choices they made were what mattered. The key actors were President Kwame Nkrumah during the transition to the NHS system, Chairman and President Jerry John Rawlings during the establishment of the user fee model, and President John Agyekum Kufour at the time the NHIS came about.

Also, in all the reforms, the government put together design teams to develop the new policies. Representing the third category of policy entrepreneurs, the design teams determined the content of the policy changes. Together with their composition, expertise, and experiences, which were fundamental to their work, the commitment and strategies of the design teams was also crucially important to how the agenda for the changes was sustained at the formulation stage. These actors included Dr. Brachott, Dr. Adibo and the seven-member design team for the NHS system, the user fee model, and the NHIS, respectively.

Sometimes, particularly during the establishment of the NHIS, the role of the design team was extended to the adoption and implementation stages. However, adoption processes was usually championed by key policy entrepreneurs at the presidential, cabinet and parliamentary levels. Champions included parliamentary committees and members of the majority side of the legislative assembly, whose arguments, defence and votes, were critically important in overcoming opposition to the changes. On the other hand, the implementation stages were shaped by special teams of implementation and service providers. Sustaining the changes also required governmental commitment and the support of new constituencies generated by the new policies overtime. Mainly, these actors defended the changes against

immediate reversal. In this respect, the fourth, fifth and sixth categories of policy entrepreneurs were mainly composed of the key actors involved in the adoption, implementation and sustenance of the policy changes at hand, respectively.

Finally, all the health care changes were favoured by Ghana's political system and institutions, which minimized opportunities for interests to oppose policy changes and helped policy entrepreneurs push through their ideas with ease, at least at the adoption stages<sup>13</sup>. For instance, the NHS system and the NHIS were pursued within a democracy by governments with a majority in a parliament largely shaped by party discipline. The user fee policy, on the other hand, was pursued by an authoritarian government which did not have a legislative body.

To explain the path-departing changes underlying this study, one must pay attention to all three factors discussed above. That said, the commitment and strategies of the policy entrepreneurs were fundamental to explaining why the changes occurred despite the countervailing factors. This is because, as indicated in the subsequent chapters, even those policy proposals that failed also faced windows of opportunity and institutional configurations that should have favoured their success.

The strategies of the policy entrepreneurs in this study were diverse, but they can nevertheless be classified as either soft or hard. The soft strategies embodied the use of compensations (financial remuneration and other rewards), ideational tools and mechanisms (framing, public education, consultations, and negotiations and compromises), underground approaches such as layering (adding new policy elements alongside existing ones), and other tactical measures (incremental versus rapid rollout of the policy, the use of narrow versus broad

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<sup>13</sup> The ease with which institutional configurations offered reformers the opportunity to push through their agenda, however, should not be construed as if the institutions played independent roles. This is because interest groups utilized different venues, including street demonstrations, to oppose change. Thus, reformers almost always had to complement institutional opportunities with political strategies before they could adequately overcome pressures from vested interests and push through their proposals. In fact, the reformers would have failed if they had not strategized in seizing the opportunity provided by the concentrated political institutions.

design teams, decentralizing the authority of implementation, using political associates, accommodating interests of diverse interests, and strategic timing of reform). Hard strategies included the use of repressive mechanisms (brutalizing, arresting, detaining or banning opponents and media censorship).

This study, therefore, contributes to the dynamic or actor-centered institutionalist literature by showing how the window of opportunity thesis formulated by Kingdon (2004) may be combined with Grindle's (2004) dynamic political process model. Both frameworks emphasize the central role of policy entrepreneurs in ensuring path-departing policy change; as suggested, the two theories complement one another nicely. In combining these two approaches, this dissertation also engages with other concepts and theories, such as Hacker's (2003) concept of policy drift, Streeck and Thelen's (2005) concept of layering, and Campbell's (2004) concept of translation, as well as the ideational scholarship on framing (for example, Blyth, 2002; Campbell, 2004; Béland, 2010). However, this study introduces additional mechanisms of policy change—the use of repressive strategies such as banning existing political parties and introducing media censorship, among others. It also reveals that the use of political strategies may create challenges, which can generate a new momentum for an immediate reversal of path-departing policy changes. Finally, it suggests some modifications to a number of common perceptions within the welfare state literature that focuses on path dependency, globalization, partisan ideology and interests.

## **1.6. Plan of the Dissertation**

The next chapter reviews the theoretical literature on policy change to explore its strengths and weaknesses, particularly when it comes to explaining the radical changes in Ghanaian health policy. Drawing on the critique of this literature, the chapter lays out an analytical framework that focuses on windows of opportunity, political commitment, reformers' strategies and

institutional processes to explain radical health policy changes in Ghana. Chapter Three focuses on the research design and methodological framework of this study, including their strengths and weaknesses and the justifications for using these methods. Chapters Four, Five and Six examine, in chronological order, the three main episodes of radical health policy change in Ghana since independence. They do that by analysing both grey and published literature on health policy change as well as the semi-structured in-depth interviews I conducted in Ghana concerning the key actors, process and factors underlying the changes. These chapters are structured in ways that not only explain the occurrences of the radical changes, but also seek to address the fundamental weaknesses associated with much of the existing literature on policy change, identified above. Hence, each of these chapters begins by exploring the nature and the magnitude of the change before expanding to the analysis of how and why the change occurred, among other issues. Chapter Seven summarizes the main findings of this study. In particular, it interprets the results discussed in the analytical chapters in light of the purpose and research questions that underlie this study before stressing its relationship and contribution to the existing literature on health care policy change. Based on the observations made, the analytical framework is reassessed using examples from the three cases of policy change discussed above. The outcome of the above exercise then informs the key lessons drawn from the study and their implications for public policy practice, particularly for domestic and international actors interested in shaping health policy and ultimately health outcomes in Ghana and other LICs facing similar challenges. The final section of the chapter explores the implications of the dissertation for future research on policy change in health care.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1. Introduction**

While the health care literature on the causes of policy stability and change was initially dominated by frameworks and concepts that emphasized stability, it has since developed several sophisticated perspectives and models that explain change. As far as health care reform in SSA is concerned, as suggested below and indicated in the preceding chapter, these perspectives include functionalism, interests, institutionalism, partisan politics and globalization.

In this chapter, I examine these five main perspectives and then develop an analytical framework that explains how and why the radical policy changes in the Ghanaian health system occurred within the relatively short time frame of four decades. By examining these perspectives, the chapter observes that due to the failure of contemporary analyses of policy stability and change to adequately focus on the dynamism embedded in policy change, accounts of how radical policy change could take place even within an unusually short period of time and in contexts theoretically expected to make such changes unlikely are sidelined. For instance, by emphasizing vested interests, path-dependency or institutional friction, the above perspectives largely fail to account for instances where change may be pursued in the absence of crisis, or in the presence of strong vested interests and path-dependency.

The study complements existing perspectives to better explain the radical changes in the Ghanaian health policy and how they could be attained within an unusually short period of time and despite certain countervailing factors. The study draws ideas from the dynamic or actor-centered institutionalist literature, particularly focusing on Kingdon's (2003) window of opportunity thesis and Grindle's (2004) dynamic political process model. The advantage of combining the two approaches is that the window of opportunity thesis enables us to ascertain



the factors that trigger policy change, and the dynamic political process model focuses on what happens afterwards. Besides enabling us to ascertain the extent of dynamism embedded in the process of institutional change, Grindle's (2004) analytical approach also provides an opportunity to explain path-departing change that occurs despite the odds. This study complements both analytical approaches with the historical institutionalist approaches to radical policy change involving policy drift, layering and translation, as well as the framing school and additional strategies employed by reformers in Ghana, including the use of repression.

The emphasis on the reformers in the analytical framework that underlies this study is also reflective of (a) the recent trend in the institutionalist literature to view institutions as dynamic, actor-centered, reflexive and mutually constitutive of actors and rules, and as a "non-deterministic context for action" (Jackson, 2010, p. 80; see also, Scharpf, 1997; Streeck & Thelen, 2005; Pancaldi, 2012) and; (b) the peculiar politics of policy change in the developing world where, because of the less developed nature of institutions and the centrality of implementation to the policy change process, reformers have become far more important players in policy change than in the developed world, where those structures are relatively developed (Grindle, 2004; Carroll & Ohemeng, 2012).

The next five sections examine each of the perspectives mentioned above, stating their basic claims, and exploring their strengths and weaknesses based on the existing literature and a discussion of Ghanaian health policy. Then, in the final section, the analytical framework of this dissertation is put forward.

### **2.1.1. The Functionalist Perspective**

As Weyland (2008) indicated, the functionalist perspective has been one of the prominent frameworks used to explain radical policy change. With its undertones in sociology, the functionalist perspective views policy change as essential for system improvement. Particularly, it considers policy change as a systemic response to policy challenges or deficiencies (Weyland, 2008). Thus, for the functionalists "[a]s challenges were bound to trigger responses, problems would find resolution" at all costs (Weyland, 2008, p. 285).

This traditional functionalist perspective emphasizing that problems trigger corrective responses has attracted the attention of many policy scholars particularly those from the rational choice school (Weyland, 2008). However, it is criticized for failing to specify the causal agents and mechanisms through which problems trigger reforms (Weyland, 2008). According to rational choice theorists, for instance, "only individuals are political actors – and individuals do not necessarily care about the system's survival needs" (Weyland, 2008, p. 285).

In much of this debate, health care scholars have been relatively silent. However, as Wilsford (2010) argued, a more sophisticated functionalist perspective has been introduced into the health care arena more recently. Rothgang, Cacace, Götze and Schmid (2008), and Schmid, Cacace, Götze and Rothgang (2010) note that policy convergence may serve as the starting point of this renewed interest in functionalism. In these studies, the authors show how, in a response to similar problem pressures, Britain, the US, and Germany developed solutions specific to their health care systems. Thus, the British NHS, the US market-based health care system, and the German, Bismarckian social health insurance system reached a state of institutional convergence in terms of policy objectives.

Indeed, the new approach to functionalism that Schmid et al. (2010) and Rothgang et al. (2008) provide useful insights for both present and future health care research. The novelty of the approach they used - popularly referred to as the "heuristic model of health care system

change” - is that it introduces some causal mechanisms and agency in the policy change process. They argue that

adaptive responses to system deficiencies do not develop automatically. Within a competitive environment, efficient answers to problem pressure may spread via evolution. For health care systems that hardly compete with one another in a given area, an additional mechanism for structural innovation and diffusion is needed. Adaptive responses may require decision of policymakers and subsequent implementation through local actors...This may include considering the perception of problems by relevant actors and also their beliefs about strategies that may improve the efficiency of health care (Schmid et al., 2010, p. 463).

Despite these insights, the new functionalist perspective still lacks adequate incorporation of agency. In concluding their study, for instance, Schmid et al., (2010, p. 480) simply indicate that it is “policymakers and their perception of functional deficit that trigger reforms”. In general, the new functionalist perspective simply locates health care systems between problem pressure and policy change, reducing the impact of both actors and ideas on policy change. By construing agency in system-specific terms, the ultimate challenge of this approach to health policy change is that it can hardly explain radical health system shifts that occur within a short time, such as those that occurred in Ghana. In explaining the policy shifts in Ghana’s health system and why and how they occurred within this unusually short period of time despite countervailing factors, a complete view of policy actors and their agency is required. Hence, the functionalist perspective is inadequate to explain radical change in Ghanaian health policy. As a consequence, although the importance it accords to problems remains crucial for the analysis of policy change, turning to other approaches to explore how to explain the Ghanaian situation is equally crucial.

### **2.1.2. Interests-based perspectives**

The interest-based perspective views policy change as being shaped by vested interests (Bleich, 2002). In the area of health care, for instance, the emphasis is often placed on the role of organized medicine in health policy change (Naylor, 1986; Wilsford, 1994; Maioni, 1998). The

ability of the medical profession to influence policy change is largely based on the fact that it is directly involved in its implementation. Indeed, empirical evidence indicates that whenever medical professionals go on strike, people experience insecurity (Marchildon & Schrijvers, 2011). Another reason is that the medical profession generally has significant public trust and legitimacy, which gives it the necessary political and social capital to influence health policy change (Starr, 1982; Lawrence, 2003). Furthermore, because medical professionals directly depend on the health care sector for their salaries and other revenues, they also tend to feel the pecuniary impact of significant health policy change the most, which makes them react immediately whenever a radical policy change is proposed. Lastly, medical professionals are generally endowed with the necessary economic and the political capital and connections to veto important health policy changes (Marchildon & Schrijvers, 2011).

In their study “Physician Resistance in Canada and Belgium in the 1960s,” for instance, Marchildon and Schrijvers (2011) portray how organized medicine in both countries went to every length, including holding long periods of strike actions (23 days in Canada and 18 days in Belgium) and engaging in profligate spending, just to ensure that the fee-for-service and the contract-based system of health care (as opposed to the salary-based system) were maintained. In his study involving health care reforms in Germany, France, Britain and the United States, Wilsford (1994) also shows the extent to which the alliance between the medical profession and the Free Democrats in the German coalition government of 1989 contributed to the failure of the “Blum” reform, which would have significantly reduced the high costs of health care in Germany. Dahlgren (1990) and Mwabu (1993) also explain how Tanzania’s user fee policy was resisted by organized interests (cited in Walt & Gilson, 1994, p. 364). Buse and Booth (2008) similarly demonstrate how local and international interests cooperated to persuade the president of Uganda to overrule the Ministry of Finance and the Global Budget Support’s opposition to the Global Fund programs (that were supposed to be organized outside the

budgetary framework) in the country. The role of the Mozambican medical elites in shaping health care reforms in the 1980s has also been emphasized (Walt & Gilson, 1994). Also, Ghana was said to have implemented the most aggressive decentralization and user fee programs in Africa in the 1980s and 1990s because of the support it obtained from the medical profession (Russell, Bennett & Mills, 1999, p. 770).

The strength of the interest-based perspective is that it brings to light how collective actors impact policy change. It also highlights the political dimension of the role of these policy actors in policy change, suggesting that actors may also be ultimately concerned about protecting their interests rather than finding rational solutions to systemic problems, a perspective that characterizes the functionalist literature.

Despite its strengths and inherent ability to explain radical change, however, most analyses of health policy change, focusing on the role of interests, overemphasize the power of vested interests. This assumption neglects instances whereby the perceived interests of policy actors may change with respect to changes in ideas and circumstances (Béland, 2010). It also ignores situations that are common in many transitional and developing economies, including SSA, where the medical profession is less organized and less focused on the broader policy dimensions than in the examples above (Cunningham, Mitchell, Narayan & Yusuf, 2008; Munyaradzi, 2010; Siket, 2010). The inability of organized medicine to shape the trajectory of policy change in developing countries may be explained by a number of factors. First, unlike their counterparts in developed countries, medical professionals in the developing world lack a history of autonomy from the state. This situation generally makes them perceive the state as an institution to obey rather than a partner that can be opposed when specific policy decisions are concerned. This perception may have arisen because in many developing countries, the state usually bears almost the full costs of educating medical professionals (Hagopian et al., 2005). Medical professionals in many developing countries also lack the required

organizational, economic and political capital to veto health care reforms (Siket, 2010). Agyepong and Adjei (2008), for instance, note that the Mutual Health Organizations (MHO) in Ghana were unable to influence the 2001 national health insurance policy, which was perceived to be unfavourable to their interests, because of ineffective organization. That is, since most of their membership were poor rural people, the MHOs were unable to forge any strong united force that would have effectively opposed the new policy. Similarly, until recently, health workers in Tanzania were forbidden from engaging in strike actions to pursue their interests (Buse & Booth, 2008, p. 14-15).

In view of the above problems they face, it is argued that many medical professionals in SSA usually adopt the “exit” option (Hirschman, 1970) to address their grievances: they migrate to developed countries instead of pursuing their interests at home, within the political arena (Hagopian et al., 2005). Hagopian et al. (2005) reveal that about 11,000 physicians trained in SSA are practicing medicine in the US, Canada and the UK alone, with a significant number of them migrating in the last 20 years, after IMF/World Bank SAERP was introduced in the region. The SAERP was a factor because it reduced budgetary support for the health sector of many African states (Møgedal, Steen & Mpelumbe, 1995). And, although user fees were expected to generate new financial revenues for the health sector in SSA, they were found to be limited, possibly because the utilization rate of health care reduced drastically after the policy was implemented (Møgedal et al., 1995). Above all, the SAERP led to a reduction in the salaries of public-sector workers, including physicians, thereby creating a strong incentive for physicians to leave their national health care sector for “greener pastures” elsewhere (Hagopian et al., 2005). Nevertheless, despite the above evidence, there are clear instances in Ghana where labour related interests have been successful at averting radical health policy changes (Arhinful, 2003).

By focusing on vested interests at the expense of interests that are dynamic and changing, most interest-based studies tend to overstate the role of structure at the expense of agency, which is a crucial aspect of the role of interests in policy change. Focusing on the structural dimension of the role of interests, therefore, most interest-based studies are able to explain how interests obstruct rather than facilitate change (Grindle, 2004). With respect to the cases underlying this study, the interests against change were later brought on board to pursue the same changes they had opposed. Thus, while being important, the interest-based perspective may have significant limitations in explaining radical changes in Ghanaian health policy.

Despite these limitations, the interest-based perspective cannot be completely neglected. For example, while ineffective in having a direct impact on the policy trajectory, the exit option usually employed by medical-profession interests in SSA may indirectly impact health reforms over time (Hirschman, 1970). Furthermore, although organized medicine in the developing world is usually unable to influence health policy change in the early stages, it is usually powerful in shaping those changes during the implementation stage (Béland & Ridde, 2014). As the analysis chapters will show, in the absence of a strong organized medicine, other interests, such as trade unions, may emerge as forces to reckon with in pursuing shifts in the health policy trajectory even in a developing world. Thus, despite its limitations, the interest-based perspective could offer some assistance in explaining changes in Ghanaian health policy, as long as the focus moves away from only doctors, at least, during the adoption process.

### **2.1.3. The Institutional Perspective**

In contrast to the interest-based perspective, the institutionalist perspective argues that interests do not operate in isolation from established institutional structures. Rather, institutions regulate all political activities, including those of interest groups and the very strategies they tend to

employ in pursuing their interests. In this respect, explanations of policy change should be based on the nature of the political system in place – that is, whether it is centralized or decentralized, parliamentary or presidential, unitary or federal and democratic or nondemocratic – and the extent to which it allows interest groups to veto policy change (Pierson, 1996). Institutionalist literature commonly assumes that a radical policy change is more likely to occur under a centralized political system with minimal veto points than a decentralized system with a significant opportunity for interest groups to veto reforms (Immergut, 1992). Hence, path-departing changes are more frequent under a unitary system of government than a federal system of government, under a unicameral democracy than a bicameral democracy, and in a Westminster or parliamentary system than a presidential system (Immergut, 1992; Pierson, 1996; Maioni, 1998; Tuohy, 1999).

This perspective has gained significant currency in the health care literature (Immergut, 1992; Wilsford, 1994; Maioni, 1998). Immergut (1992) shows how different institutional configurations in Switzerland, France and Sweden shaped the activities of organized medicine and the divergent policy outcomes in these three countries. For instance, the institutional emphasis on referendums in Switzerland, unlike in France, created a wider window of opportunity for Swiss organized medicine to veto health insurance proposals it opposed. However, with the support of their parliamentary system that created only a minimal veto point, the reformers in France were able to prevent organized medicine from vetoing their national health insurance proposal. Sweden was able to establish both a national health insurance policy and a national health service because its executive-dominated system happened to have fewer veto points than in France or Switzerland. Combining institutionalism and partisanship, Maioni (1998) shows how the US and Canada parted ways regarding their journey toward a modern health insurance system. She observes that Canada, unlike the US, was able to institute a universal health insurance because of its Westminster model and the multi-party system, which



contrasts with the US presidential and bi-party system. She notes that Canada's Westminster model of democracy, which allows minimal veto points for organized medicine to oppose reform proposals, enabled it to pass a comprehensive health insurance system as opposed to the US presidential system, which allows a significant veto point for interests to block reforms.

In the health care literature on the developing world, the veto point thesis has centred on a comparison between authoritarian and democratic regimes. According to Buse and Booth (2008), the ability of organized interests to influence policy change in the developing world has improved after many of these countries transitioned to democracy in the 1990s, as compared to when they were under authoritarian rule. In Uganda, the transition to democracy enabled health workers to influence policies as the country got close to elections (Buse & Booth, 2008). Also, although health workers are prohibited from undertaking strike action in Tanzania, this law failed to prevent them from embarking on industrial action over pay after the country transitioned to a democracy (Buse & Booth, 2008).

North (1990), Pierson (2000) and other institutionalists have also explored policy legacies and path dependency. According to this perspective, a previously legislated policy can create lock-in effects, which serve as a path for subsequent policy changes (Pierson, 2000). In path dependency, it is argued that structural forces dominate the process of policy change, leading to either stability or incremental change (Wilsford, 2010). A typical path-dependent health care system is that of the US. In his study on path dependency, Wilsford (1994) demonstrates how the longstanding structural factors embedded in the US political system put the US health system on a track-dependent path. These factors include the US presidential system, coupled with the principle of separation of powers, the bicameral legislature, and federalism. Using the example of Clinton's 1993 health insurance plan, which sought to extend insurance coverage to all Americans and to create regional alliances and competitive provider networks in order to reduce costs, Wilsford (1994) reveals how the above institutional logics,

associated with strong vested interests within the existing health care system, made path-departing change unlikely. Regarding the US and using a similar perspective, Pierson (1994, 1996) shows how path dependency shaped changes in the Medicare program, and why Medicare retrenchment policies have proven to be so unpopular in the US. Whereas it is mostly applied in analysing policy change in the public sector, path dependency has also been observed to be applicable to the analysis of the development of private health care and social benefits (Hacker, 2002; Klein, 2003; Béland & Hacker, 2004; Béland, 2010). For example, a fundamental reason why the Truman government's proposed national health insurance policy failed to gain adequate political support was high public confidence in the ability of the private sector to provide effective health insurance coverage at the time, and in the predictable future (Béland, 2010).

In the developing world, including SSA, the path-dependent literature has focused on institutional colonial legacies (Alubo, 1990; Mogedal, 1995). For instance, citing the user fee policies in Tanzania, Ghana, Zambia and Zimbabwe, Alubo (1990) suggests that a colonial or elite-centred understanding of health care has reshaped policy change in the post-colonial era, leading to the marginalization of the poor. Batley (2004) also shows how the public provision of health care in India, Ghana, Sri Lanka and Zimbabwe has been shaped by a colonial system of health care where the government was the main actor. The author indicates that the fundamental principles of both the colonial and the post-colonial health systems are basically the same, the only difference being that post-colonial governments have added “redistributive and nation building intentions” to these colonial systems (Batley, 2004, p. 36).

Despite the emphasis on veto points and path-dependency, a major weakness of the institutionalist literature, as Wilsford (1994) acknowledges, is its inability to explain radical change (i.e., change outside the existing institutional logics). To address this gap, Wilsford (1994) draws our attention to *events* or *conjunctures*, such as economic crises or changes in

government. These “focusing events” (Kingdon, 1984) can create a window of opportunity for a path-departing policy change to occur (Haggard & Webb, 1993; Wilsford, 1994; Pierson, 1996). For example, Wilsford (1994) shows how factors such as skyrocketing social security deficits, a global recession, high hospital expenditures and the appointment of a resolute reformer, Jean de Kervasdoue, as the new Director of Hospitals contributed to the French government's ability to initiate a radical reform that led to a significant reduction in health care costs in the post-1984 period. Similar conjunctural factors aided in the sea change that characterized Germany's health care system in 1992. This reform benefitted from the appointment of a new and committed minister of health, Horst Seehofer, in 1992; the grave economic recession; the high costs of the German unification agenda; the overwhelming dominance of the Christian Democrat-led coalition in the Bundestag and Seehofer's effective lobby of the Social Democrats who had won the Bundesrag; and high wage costs, which was driving away German exporters, such as BMW and Mercedes, to other countries.

Recessions in many parts of Africa were also described as the fundamental cause of health care change in SSA in the 1980s and 1990s (Møgedal, 1995; Batley, 2004). Gilson et al. (2003, p. 36), reveal the way the political transition in the 1990s in South Africa and Zambia presented a great opportunity in both countries to pursue sea changes in health policy. Apart from bringing a new authority to power, the transitions brought the widespread problems facing the health systems of both states to the fore. The delay in implementing SAERPs in Zambia compared to Ghana can be attributed to the fact that the latter had an earlier transition than the former. The transition from civil war to political stability in the 1990s is also believed to have triggered health sector reforms in Mozambique during that decade (Møgedal, 1995).

Despite the introduction of conjuncture, the institutionalist literature is criticized for limiting the sources of significant policy change to exogenous or structural factors (Mahoney & Snyder, 1999). In this respect, the institutionalist perspective significantly neglects the role

of endogenous factors in radical policy change. Institutional studies such as those of Mahoney and Thelen (2010), Streeck and Thelen (2005), and Hacker (2004) have incorporated endogenous variables into their analytical frameworks. These variables include layering, conversion, displacement, and policy drift. Layering is about how an incremental add-on to the existing institutional structure can sometimes transform an existing institution (Streeck & Thelen, 2005). Conversion occurs when the goals and actors of the existing institution are changed through a review or a reinterpretation of the principles underlying its sustenance (Streeck & Thelen, 2005). Displacement takes place when the existing policy or institution is phased out and replaced (Mahoney & Thelen, 2010). As a mechanism of policy change, policy drift emphasizes how legislative or policy inaction can foster deep transformations related to changes in the social and economic environment (Hacker, 2004).

An advantage of this new institutionalist approach to policy change is that it incorporates a greater amount of agency into the analysis of policy change than the path-dependency literature does. Particularly, it shows how policy actors can devise strategies to pursue policy change despite the existence of structural factors. This approach, nevertheless, has some limitations. As Béland (2010, pp. 621- 622) demonstrates, "it is not always clear whether concepts like conversion, layering, and policy drift explain policy change... they describe concrete episodes of incremental change without really explaining them". According to him, the historical institutionalist approach needs to show the mechanisms through which actors select and develop strategies of incremental changes in a particular policy environment.

Looking at the Ghanaian case points to some of the strengths of the institutionalist perspective. First, all three policy changes occurred under political institutions that were largely centralized – a purely presidential-unitary system in the case of the NHS system, an authoritarian in the case of the user fee system and a hybrid-unitary democratic system in the case of the NHIS. Second, they occurred during critical junctures – the economic boom and

transition to self-government in the 1950s/1960s in the case of the NHS system, the economic crisis and the transition from the PNP democratic regime to the PNDC military regime in the 1980s in the case of the user fee system and the debt problem and the transfer of power from the NDC democratic regime to the NPP democratic regime in the 2000s in the case of the NHIS. Also, while it could be useful to describe the episodes of change at hand, the punctuated equilibrium framework cannot really explain how the changes were pursued by the key actors behind them. In other words, it fails to meet the explanatory logic of this study. Finally, the radical changes were not as abrupt as described by the punctuated equilibrium thesis, which may partly vindicate the historical institutionalist perspective by Thelen and others. But, on their own, are the veto point and the historical institutionalist perspectives enough to explain how a policy change occurs?

Both theoretical and empirical evidence suggest that in many instances historical institutionalism may not be powerful enough to explain path-departing policy change. Haggard and Webb (1993, p. 146), for instance, find the institutional veto point thesis too simplistic in its assumption that authoritarian regimes are immune to pressures from interests. As they argue, “authoritarian regimes may not be accountable to the electorates, but they may ... remain vulnerable to interest-group pressures”. Authoritarian regimes also care about their legitimacy, and, therefore, “are likely to initiate reforms aimed at increasing...benefits as a way of appealing to the working class” (Kpessa, 2009, p. 10) rather than introducing a user fee policy, which is potentially agonising to them (Pierson, 1996). Focusing on the inability of the British government to pursue radical retrenchment in its social policy during the 1980s, despite its centralized political institutions, Pierson (1996, p. 145) also challenges the institutional veto point thesis.

While cohesive systems concentrate authority, they also concentrate accountability. The former tendency facilitates retrenchment [radical change], but the latter impedes it. Where authority is centralized, the public knows that the government of the day can prevent groups from suffering cutbacks. Strong governments, anticipating the high

political cost of retrenchment, may forgo the opportunities provided by concentrated power. Thus, the theoretical basis for believing that government cohesion facilitates retrenchment [radical change] is weak.

Pierson (1996, p. 145) further notes that “advocates of retrenchment must persuade wavering supporters that the price of reform is manageable”, a task that requires more than mobilizing institutional forces. This factor will be more fully described in Chapter Five.

The above critiques of the institutionalist perspective are on full display in the trajectory of Ghana’s health policy. For example, as indicated in the preceding chapter, although it was an authoritarian regime, the National Liberation Council (NLC) withdrew its user fee policy in the face of opposition during the late 1960s (Arhinful, 2003). Also, although the NDC government has the institutional capacity to pursue its "one-time premium" policy, as indicated above, it has yet to do so since it regained power in 2009. Ghana has also experienced a series of crises and multiple changes in government since independence, though most of them never resulted in radical policy changes (see Haggard & Webb, 1993).

In view of the above limitations, this study suggests that the analysis of radical policy change must move beyond the analysis of institutions to account for how other factors may have complemented the role of institutions in achieving change, including why and how it may have occurred within a relatively short time frame despite the odds.

#### **2.1.4. The Partisan Politics Perspective**

The partisan politics perspective explains policy change based on the ideals and the interests of the political party in power. Political parties are formed through an amalgamation of individuals whom, as a result of sharing similar beliefs or ideology about life, coupled with a perception or experience of not being able to realize those ideals outside of government, have come together as a group to pursue those ideals for the common good of all people, particularly their own members. Thus, like many social groups, the members of a political party are united

by the ideals or ideology they share. Unlike other social groups, however, political parties believe that they can pursue their ideals only through capturing the political power of the state. Thus, apart from being the prime motivator of their existence and, of course, their ultimate goal, the ideology of the party serves to dictate the actions of the government in power and the medium through which the parties interact with their respective constituencies. Hence, Hick (2011) argues that ideologically left governments support and pursue significant social policies, while ideologically right parties establish minimal social policies. Starke (2010), for example, shows how the pro-market reforms of the right-based National Party of New Zealand were reversed after 1999 when the left-oriented Labour Party assumed power.

Over time, however, the partisan politics perspective has been interpreted in other ways, which divert from its original focus on ideology. Most of these interpretations put power at the centre of the analysis. For instance, Haggard and Webb (1993) argue that policy change is conditioned by the amount of political capital the change is expected to generate for the party in power. Thus, if it is perceived that a particular reform agenda would generate political support for the government, then it will be carried out (even where there is evidence that it is inefficient). However, a reform would not be pursued if it is perceived to be unpopular and likely to result in shrinking the existing support base of the party (Pierson, 1996). In order to increase political support, Haggard and Webb (1993) argue that incumbent governments generally pursue the enactment of large social programs close to elections when votes are needed rather than when elections are in the distant future. Alternatively, newly elected governments pursue reforms immediately after the election in order to establish their own constituencies and build legitimacy.

A significant amount of evidence also exists about the political-electoral dimension of reforms. For instance, in the 1990s, due to partisanship, both Zambia and South Africa chose to introduce user fee and user fee removal policies instead of creating prepayment mechanism

and a social health insurance scheme, respectively (Gilson et al., 2003). The study revealed that although they were found to be more technically superior to their alternatives, both the social health insurance and the prepayment schemes were rejected because there was inadequate political and partisan support for them.

In their five-country comparative study (Ghana, Zimbabwe, India, Sri Lanka and Thailand), Russell et al. (1999) also show how politics played a role in the implementation of the New Public Management (NPM) reforms such as decentralization and cost-sharing in SSA. They concluded that the governments merely paid superficial attention to the reforms because they were found to require not only political leadership and administrative competence, but also significant changes in organizational culture, which were believed to be politically suicidal. Focusing on Uganda, Burkina Faso, Ghana, Senegal, Burundi and Liberia, Meesen et al. (2011) also showed how politics affected the implementation of user fee elimination policies in SSA in the 2000s. They found that in many of the countries, the removal of user fees was actually a vertical process, involving high level government officials (usually the president or prime minister and a few bureaucrats) making the decision, sometimes not only to the surprise of ordinary people, but also the very ministries and ministers officially responsible for implementing those policies, as in Burundi. In Uganda, on the other hand, although several empirical studies had revealed the need to remove user fees, the decision was delayed until the 1991 elections, when the opposition parties pushed it onto the agenda (Meesen et al, 2011). Having seen that his re-election was at stake, the president quickly consulted with the Ministry of Health and Finance on how much it would cost to remove the user fees and, shortly thereafter, the user fee removal policy was announced (Meesen et al, 2011). Agyepong and Adjei (2008) also show how partisan and electoral politics shaped the process of introducing a national health insurance policy in Ghana in 2001. They observe that because experts' knowledge was not in favour of national health insurance at the time, most were sacked from



the committee responsible for drafting the insurance bill, leaving only political actors to make all the fundamental policy decisions.

The partisan political perspective is limited in terms of explaining the radical health policy changes that occurred in such a short time in Ghana. The reasons, as indicated above, include the fact that both the user fee policy and the National Health Insurance Scheme (NHIS), in particular, were introduced by governments that belonged to the side of the ideological divide which should generally avoid such policies. Also, they were somehow unpopular among the general public, including the Trade Union Congress (TUC) and the lower class, who form the largest section of the voting public and whose support, according to the existing literature (Herbst, 1991; Hutchful, 2002), is crucial for sustaining the government in power. In fact, it was not only democratic governments such as the CPP, NDC and NPP that needed the support of these actors; dictatorial governments such as the PNDC also required their support to maintain legitimacy and sustain themselves in power (Haggard & Webb, 1993).

Despite the above limitations, however, some partisan political calculations may have taken place, given the politico-economic conditions surrounding the changes. This study, therefore, provides an opportunity to unearth these factors and show how they interacted with other factors in the policy change processes.

#### **2.1.5. The Globalization Perspective**

The globalization perspective appears to have been the commonly employed theory of institutional change in the developing world, particularly after the 1980s (Ohemeng & Ayee, 2012). This perspective focuses on how the unbalanced nature of the international system allows transnational actors and institutions to have a disproportionate impact on domestic policy (Selin & Linnér, 2005). In the developing world, the globalization perspective often focuses on the influence of major international actors such as the United Nations, the

Organization for Economic Corporation and Development (OECD), the World Health Organization (WHO), and more especially, the IMF and the World Bank on public policies of sovereign states (Grindle, 2000). Generally, transnational actors shape domestic policies through expert advice; however, in developing countries including those in SSA, their role extends beyond just advisory services to financial assistance (Batley, 2004, p. 39). Whereas international assistance made up an average of 2.8% of total health care spending of developing countries in the 1990s, it represented about 20% of health care spending in Africa (excluding South Africa) (Cassels, 1995). Due to high levels of international support for health policies in developing countries, particularly in Africa, donors are said to play a significant role in domestic health policy making. Møgedal's (1995) study on the health care reforms in Tanzania, Botswana, Mozambique and Zambia in the 1990s, for instance, suggests that international actors are usually the agenda-setters of domestic reforms.

Although the globalization perspective has gained significant currency in the literature on SSA, a number of scholars overemphasize one of the mechanisms through which transnational actors shape policy – the use of conditional aid (Ohemeng, Carroll & Carroll, 2012). This is generally referred to as the imposition thesis (Selin & Linnér, 2005). While it makes an important contribution to the policy change debate, the imposition thesis is problematic in many respects. For instance, as Collins et al. (1999, p. 78) indicate, apart from the conditionalities, an international actor like the World Bank also partakes in foreign aid coordination in developing countries. Acting as a proposal actor and a global think tank, the Bank also provides expert assistance to developing countries (Orenstein, 2008; Béland & Orenstein, 2013). In support of this assertion, Meesen et al., (2011, p. 25) in particular, reveal the extent to which transnational actors and non-governmental organizations (NGOs) advocated (rather than imposed) user fees removal in countries like Liberia and Burundi. In fact, international actors also appear to have a more developed and systematic model of reform

than many countries, as exemplified by the World Bank's World Development Reports in 1993 and 1996 as well as its yearly reports about sovereign countries all over the world. This may appeal to various states (Collins et al., 1999, p. 78). In addition, the World Bank's reform agenda is often extensive, covering a wide range of sectors beyond health care. The Bank also works in collaboration with domestic governments, officials, civil societies, think tanks and research institutions in the form of broad policy networks that do not involve imposition in the traditional sense of the term (Collins et al., 1999, p. 78). Batley (2004) observed that in reforms in developing countries' social sectors (e.g., water and health), including SSA, "core government officers, together with international agencies, were ... the main initiators of change" (p. 50). As well, the Bank helps domestic policy actors travel abroad with the objective of exposing them to best practices elsewhere (Collins et al., 1999). It must also be noted that the Bank's ideas are themselves unstable (Béland & Orenstein, 2013). For instance, it promotes different policy ideas at different times, suggesting that the Bank itself might be an agent rather than the principal in the policy change process.

In contrast with the popular imposition thesis, Collins et al. (1999) also suggest that significant policy changes in developing countries sometimes occur without the interference of the World Bank or other international organizations. This is true because, on their own, policies being implemented in one country can influence governments in other places to follow suit. For instance, many Latin American countries implemented market-based health systems in the 1990s without the influence of the World Bank (Collins et al., 1999). A number of reform initiatives and ideas have also been introduced in many developing countries since the 1990s by domestic actors and institutions, rather than through external imposition (Ohemeng, 2005). Batley (2004) indicates that South Africa and Argentina implemented market-based reforms in the early 1990s, mostly without pressure from international actors, but for internal reasons such as the end of Apartheid and inflation, respectively (Batley, 2004). Botswana was also free from

external conditionality, but pursued reforms much like the ones implemented in Tanzania and Mozambique, which did have some external influences (Møgedal, 1995). Outside Africa, it is believed that Thatcher's reforms in the UK and Reagan's in the US influenced many parts of Western Europe and New Zealand, without any imposition from international organizations (Collins et al., 1999). A similar situation is reported to have occurred in Central and Eastern Europe in the 1980s and 1990s as most of them adopted a common policy – health insurance (Collins et al., 1999).

In addition to from being a mere actor in the international system, Ghana generally occupies a weak position in the international economy, making the impact of globalization on Ghana's health care reforms a real possibility. Despite this fact, however, the extent to which international actors influenced the policy changes under study while reducing the agency and policy autonomy of national actors was not uniform. For instance, global actors appeared to have influenced the user fee policy more than the health insurance policy, and probably had similar levels of influence in the case of the NHS system. Also, the extent of their influence varied across regimes and processes; while global actors were crucial to the introduction of user fees, they were less influential during the policy's implementation. Also, the government pursued the health insurance reform, even though key international actors such as the World Bank and the IMF were opposed to it. After pursuing the reforms, however, these international actors appeared to have gained much influence over the policy's implementation and sustenance. The complexities surrounding the globalization perspective, therefore, create the need to further question its applicability to the Ghanaian case of radical health policy change.

## **2.2. Theoretical Framework**

The limitations of the above perspectives point to the need to search for a better explanation for how the radical changes in the Ghanaian health policy occurred, particularly within such a

relatively short time frame and despite many potential countervailing factors. To arrive at this explanation, I draw on ideas from recent developments within the institutionalist literature, according to which policy change is a dynamic political process where various factors interact in both complex and dynamic ways to bring about major policy changes. From the perspective of dynamic or actor-centred institutionalism, actors rather than institutions or structures are the drivers of policy stability and change (Jackson, 2010). As Pancaldi (2012) emphasizes, “even though institutions – broadly intended as formal rules and social norms – undoubtedly influence actors’ perception of reality, structure their interaction, and therefore condition policy outputs, it is simply actors that make policies” (p. 2). Thus, while it does not discount the significant role contextual factors played in policy change, the dynamic institutionalist literature depicts them as non-deterministic and as more dynamic than usually considered in much of the theoretical frameworks discussed above.

Following this perspective, a number of scholars have directed attention to the role of reformers, who may be referred to as design teams (Haggard & Webb, 1993), change teams (Grindle, 2000, 2004), programmatic actors (Hassenteufel et al., 2010), or policy entrepreneurs (Kingdon, 2003). Members of such teams might be tied to the political arena, the state bureaucracy, international organizations or the private sector, including interest groups (Grindle, 2000, 2004; Hassenteufel et al., 2010). They could also be a mix of actors from these broad constituencies (Grindle, 2000, 2004). Scholarship within this perspective emphasizes the central role of reformers in policy change. Typically, these reformers dominate key aspects of the policy process, including developing the actual content of a policy and shaping its very outcomes (Haggard & Webb, 1993; Grindle, 2000, 2004; Hassenteufel et al., 2010). Hence, as Grindle (2000) argues, focusing on how these reformers “shepherd reforms from definition through political turmoil to adoption and implementation” is crucial for the analysis of policy change (p. 2).

The basis of this approach, according to Haggard and Webb (1993), is to construe policy change as "an exercise in coalition-building" (p. 58). This means that reformers' "composition and style of work" and their ability to garner sufficient support for their proposed reforms and weaken opposition to them can directly shape policy processes and outcomes (Grindle, 2004, p. 20). In other words, the analysis of policy change must pay particular attention to how the reformers are constituted, who gets to serve on the reform team, what responsibilities they are accorded and how they tend to pursue their goals, including championing them through political, structural and institutional means.

A number of empirical studies support this perspective. Focusing on France, Germany, Spain and the United Kingdom, Hassenteufel et al. (2010) introduce the idea of "programmatic actors" who are basically drawn from the public service (current or retired), the medical profession, the legislature, academia, political parties and the private sector. They define programmatic actors as "collective actors who share policy ideas and compete for legitimate authority over sectorial policy making" (Hassenteufel et al., 2010, p. 518). What differentiates programmatic actors from all other actors in the policy process is the fact that (a) they bear similar policy ideas; (b) they possess resources such as institutional position (i.e., either situated at or near the locus of power), legitimacy or the strategic capacity to produce change; and finally (c) they are ultimately interested in change, not necessarily for material reasons, as the quest for professional recognition and personal satisfaction can also motivate them. Depending on the institutional makeup of the state, these key actors can take the form of programmatic elites, programmatic coalitions or programmatic teams.

In examining the health insurance process in France since 1981, Hassenteufel et al. (2010) show how a small group of senior civil servants collectively championed the idea of spending limits, which resulted in the dominance of the state in a health sector hitherto dominated by physicians and other non-state actors. In their book, Hassenteufel et al. (2010)

made a similar observation about the situation in Spain in the 1980s, when a group of physicians introduced a NHS system based on the British NHS model. As for Germany, its transition from a system that was wholly managed by the sickness funds to one featuring the incorporation of the regulatory state, Hassenteufel et al. (2010) stressed that it was a coalition of actors from public service, academia and the legislature that developed the idea and manned the entire policy change process. For instance, the 1992 and 2003 reforms were pursued by a two party coalition (Social Democratic Party and Christian Democratic Union - Christian Social Union ), and the 2007 reform was developed and decided upon by a tripartite commission, with membership drawn from parliament, the länder, and the political parties forming the ruling coalition at the time. In the case of health care reform in the UK since the 1980s, a loosely connected group of political advisors, drawn from the academia and the private sector, championed the policy development and change process. Their role as advisors accorded them direct access to the levers of power, which enabled them to pursue their policy goals. Thus, the authors concluded that it was these ideas-bearing and resourceful actors that shaped the transition from a corporatist to a regulatory health care system, where the state assumes a dominant role in health care management and administration (Hassenteufel et al., 2010).

In his pivotal study *Agendas, Alternatives and Public Policies*, Kingdon (2003) introduces the “window of opportunity” framework to explain when and how significant policy change may occur through the actions and strategies of policy entrepreneurs, who he refers to as “advocates who are willing to invest their resources – time energy, reputation, money – to promote a position in return for anticipated future gain in the form of material, purposive, or solitary benefits” (p. 179). As he develops his arguments, Kingdon identifies three streams that make up the policy process: the problem, the policy and the politics streams. The problem stream encompasses the issues that may capture the attention of policymakers, the policy

stream contains policy solutions and the actors designing them, and the politics stream is about political factors such as swings in national mood and electoral results. Kingdon (2003) argues that these streams operate independently from one another and are coupled either by chance or by the actions of policy entrepreneurs during short windows of opportunity when policy change is most likely to occur. Since its development, Kingdon's window of opportunity framework has inspired various studies on policy change across the world. For example, Marchildon (2014) used it to explain the establishment of the universal medical care system of Canada in the 1960s. Leiber, Greß and Manouguian (2010) also used it to explore the way the 2007 German health care reform was influenced by the central fund and flat-rate premium models of the Netherlands.

The most interesting aspect of Kingdon's (2003) framework so far as this study is concerned is that it provides a realistic understanding of the agenda setting process, particularly when and how issues and policy ideas make their way onto the policy agenda. It also helps to better understand how the strategies of policy entrepreneurs, in terms of advocacy and brokerage, matter for policy change. In explaining the radical changes in Ghanaian health policy, these two areas of the window of opportunity framework will be useful, at least at the agenda setting stage.

The fundamental limitation of the window of opportunity framework that prevents me from making it the sole analytical foundation of this study is that it focuses only on the agenda setting and alternative specification stages of the policy process, neglecting other aspects of the policy process (Howlett, Ramesh & Perl, 2009), particularly implementation and sustainability. These stages are crucial sites of policy change in the developing world (Grindle & Thomas, 1989; Parliament of Ghana, 2003, p. 167). More important for this study, in many developing countries, where institutions are generally weak and a majority of the policy changes tend to fail beyond the initial stages of the policy process, especially during implementation (Grindle &



Thomas, 1989), it is very important to explore the entire policy process. Kingdon's argument that policy entrepreneurs must have their policy initiative ready when windows of opportunity open also makes his work less applicable to Ghana, where, as suggested in this study, except in the case of the NHIS, such windows rarely open. In other words, the policy entrepreneurs in this study seldom waited with initiatives ready to be implemented once policy windows open. But even after the window of opportunity has opened and the agenda for change is set, policymakers may still have great hurdles to surmount before a significant policy change may occur. This is because opposition to policy change tends to occur after the agenda setting stage, particularly during adoption and implementation. In order to explain radical changes in Ghanaian health policy beyond the agenda setting stage, therefore, Kingdon's (2003) "window of opportunity" framework may have to be complemented with other factors, particularly Grindle's (2004) "dynamic political process" model.

Focusing on education reforms in Latin America, Grindle (2004) introduces an analytical framework that explains policy change as a "dynamic political process that unfold over time [and] as complex chains of interactions subject to the interaction of reform advocates and opponents in particular institutional contexts that are sometimes subject to alteration" (p. 15). As part of her framework, Grindle (2000, 2004) points to how "reform mongering" by key policy entrepreneurs, such as governments and design teams, among others, plays a fundamental role in instituting path-departing policy change, even when there is no window of opportunity. In such situations, she argues that the strategic choices of the reformers or policy entrepreneurs are crucial to pursue path-departing change. For instance, "reform mongering by the president and ministers" or the executive leadership is identified as critically important in setting the agenda for change (Grindle, 2004, p. 20). Some of the strategies the governments tend to employ at this stage involve capitalizing on their institutionally-vested power of appointment to fill important positions of authority with people who support their views

(Grindle, 2000, 2004). Thus, they can use appointments to put people who would support (rather than impede) change in positions of authority. They may also influence the timing of reforms by ensuring that reforms are pursued at the time the environment is conducive for change, particularly after all potential opponents have been either eliminated or convinced of the policy change. Additionally, they can set the parameters within which public debates, expert discussions and political discourses surrounding proposed reforms are pursued, for example, by determining the main issues that are being discussed (Grindle, 2004).

According to Grindle (2004), once issues have made it to the policy agenda, design teams are set up to develop proposals for reform. The kind of preferences and choices the teams put forward are fundamentally shaped by the teams' make-up and preferences rather than any governmental or interest group influences. The author makes this argument even clearer in the earlier (2000) version of the study, which focused on Venezuela, Bolivia and Argentina. She argues that the content of the policies as hammered out by the design teams "could not be clearly linked to the pressures or preferences of either domestic or international interest groups, nor directly in the electoral calculations of politicians, [as only a] little mobilization of public or international demand for reform [was sought] and the political gains they promised to politicians were often ambiguous " (p. 8). Thus, design teams are critical in policy change.

Despite the above, she notes that the most successful design teams are the ones that establish strong networks with the government in power and other domestic and international actors relevant to achieving their assigned goals (Grindle, 2004). In addition, to remain effective, the design teams should be able to make decisions easily, either through consensus, compromise or negotiations. They should also develop strategies to enhance the chances of success of their initiatives. For example, they estimate the likely losers and their potential reaction against the proposed policy. This is what is called "smoothing" (Grindle, 2000, p. 32). The purpose of smoothing is to counter actors opposed to change, and it is generally meant to

ease the way to policy change. In doing this, the design team's level of transparency, the kind of actors they decide to involve in the policy process, the issues they decide to consult or negotiate on, the atmosphere within which they decide to deliver their policy recommendations and the extent to which they are able to solicit support from political authorities matter significantly for their success. The stakeholders whose ideas matter the most are usually fully incorporated in the policy process, sometimes from the beginning, while those who matter less are just consulted after the end of the policy design stage. In fact, sometimes stakeholder involvement is completely ignored, especially where it is perceived that their role might adversely affect the chances of reform. Other strategies the design teams can employ to counter domestic interests and institutions include negotiations and consultation, by which the teams actually determine the underlying terms of reform. Grindle (2000), for example, reveals that, in Venezuela, the reform team focused on building consensus among the national elites in support for change. In the case of the reform in Bolivia, in addition to making an adjustment to the original participatory plan of the design team, an agreement was signed with the opponents of the policy, assuring them that the policy would be implemented in ways that would not undermine their interests. The design team in Bolivia went even further by amending its final policy recommendations. Despite these limitations, however, Grindle (2000) observes that the consultations and negotiations were generally undertaken merely to "put finishing touches" on already made decisions. For instance, in Bolivia, no obvious changes were made to the original policy proposal, despite the existence of a signed agreement.

When reform initiatives are publicised, usually during the legislative or adoption process, the above reformers usually lose significant level of control since the arena of policy change shifts to the public domain. At this stage, the reformers may alter their strategies. For instance, they may have to compromise with opponents rather than to confront them. For Grindle (2004), the implementation stage is also shaped by the characteristics of the

implementing agency and the relationship between the reformers and the various levels of implementation. As for the sustainability stage, during which the implemented policy must be sustained over time, it is shaped by the extent to which the reform initiatives have been able to generate new supporters, and reformers have the incentive to preserve the policy in the first place (Grindle, 2004).

As suggested in this thesis, Grindle's (2004) framework is the most systematic and convincing analytical framework for understanding the three main health care changes in Ghana since independence. This is because, beyond placing policy entrepreneurs at the centre of the study of policy change, Grindle (2004) also provides a comprehensive understanding of policy change, beginning from agenda setting and ending with implementation and sustainability. As stated above, due to the severe financial difficulties and other challenges of implementation in developing countries, including Ghana, the politics of policy change usually heat up after the agenda-setting and alternative specifications emphasized by Kingdon's window of opportunity framework. Thus, in contrast to Kingdon's (2003) most useful but most limited approach, Grindle's (2004) policy as political process framework takes a broader look at policy change, which puts it in a better position to explain the three episodes of radical policy change at the centre of this empirical analysis. It has an additional benefit of providing mechanisms by which change may be pursued in the face of strong obstacles.

Grindle's (2004) analytical framework is not without limitations, however. First, it does not account for how certain contextual factors related to the nature of the economy and political transitions may create the impetus for policy change to occur. For instance, as she emphasized, "episodes of reform were not systematically associated with particular economic conditions or with particular characteristics of party systems, governing coalitions, or electoral cycles. Rather, the emergence of reform initiatives is almost universally traced to the interests and actions of political executives or those closely associated with them; their concerns to improve

education was generally part of broader political and policy agendas they espoused..." (Grindle, 2004, p.20). To capture the contrary perspective more clearly in the analytical framework of this study, I draw ideas from Kingdon's (2003) "window of opportunity" framework. By so doing, I show how certain conjunctural factors, such as the state of the Ghanaian economy, the crisis of the health care system, or changes in government, created "policy windows" which were seized upon by policy entrepreneurs to bring about path-departing policy change. Second, Grindle's (2004) framework proposes change strategies that are largely mechanistic and rationalistic, neglecting a systematic analysis of those strategies that involve the use of cognitive and normative ideas and frames (Kahneman & Tversky, 1984; Hall, 1993; Blyth, 2002; Stone, 2002; Fischer, 2003; Padamsee, 2009; Leiber et al, 2010; Starke, 2010; Béland & Cox, 2011; Mehta, 2011; Wincott, 2011) and feature subtle and incremental, but cumulatively transformative strategies like layering new policies on the top of existing ones (Hacker, 2004; Thelen, 2004; Streeck & Thelen, 2005; Thelen, 2010). Finally, Grindle's (2004) analysis is limited in relation to the use of coercive mechanisms to pursue change. This study provides additional strategies of policy change, such as the use of brutality, media censorship, and the co-optation or banning of oppositional groupings and activities. In an attempt to transcend these limitations, the analytical framework used in this study also draws selectively on historical institutionalism, frame analysis, and the analysis of repressive political strategies.

As indicated above, the historical institutionalist approach to radical policy change focuses on the mechanisms of change that are usually endogenous, and gradual, but all the while "transformative" (Thelen, 2010, p. 45). They include displacement, layering, conversion, and policy drift (Thelen, 2010). These four mechanisms, though incremental, could lead to a path-departing change over time. In his study on institutional change and globalization, Campbell (2004, 2010) introduces additional change mechanisms, such as bricolage and

translation. Bricolage "involve[s] the rearrangement or recombination of institutional principles and practices in new and creative ways, [while translation points to] ... the blending of new elements into already existing institutional arrangements" (Campbell, 2010, pp. 98-99). Although not necessarily incremental in nature, these two additional mechanisms complement the ones Thelen (2010) discussed and are relevant for an analysis of radical policy change. These mechanisms are important because they help to devise a framework that is more dynamic than the path-dependency/punctuated equilibrium approach, which is why the tools they develop are appropriate for this thesis and its reformer-centred approach.

Exploring the cognitive and normative mechanisms of policy change, scholars have explored the role of framing processes. In particular, how reformers may manipulate the cognitive orientation of potential opponents and the public at large to legitimize their programs (Campbell, 2004). Two main understandings of framing are available in the literature – ideational and psychological. The ideational dimension emphasizes the use of historically generated ideas and cultural symbols residing in the foreground of policy debates to legitimize reforms (Campbell, 2004). The psychological dimension, on the other hand, emphasizes hard-wired mental processes that make individuals either support or oppose radical policy change (Parsons, 2007; Weyland, 2008).

It is argued that through an appropriate framing device, one could help shape public perceptions about a particular policy and also turn a potentially “unacceptable” policy into an “acceptable” one. Various suggestions have been advanced regarding how to launch an effective framing campaign. For instance, focusing on the ideational dimension, Campbell (2004) and Béland (2005) suggest a two-dimensional approach to an effective framing campaign. In one dimension, the framer should launch a “discursive opposition” (Campbell, 2004, p. 98) to the status quo by portraying it as both incredible and unacceptable. This is supposed to create urgency for change. Thereafter, within the other framing dimension, the

framer should orient the public in a particular way to justify their reform proposals (Béland, 2005). Following a similar approach, Bahtia and Coleman (2003) examine the conditions under which framing processes embedded in policy discourse can serve as means to bring about policy change, even in the absence of change in political institutions and interests. Using the cases of health care reforms in Canada and Germany in the 1980s, they argued that Germany was able to pursue an extension of solidarity (from a class-based approach to a universal approach) because the opposition party was able to launch a powerful, challenging discourse that generated a broad consensus among policy elites about the nature of the status quo, and offered a normatively persuasive and convincing cognitive solution to the problem at hand. However, in Canada, the opposite discourse (involving a reduction in solidarity) generated by the Alberta provincial government was unpersuasive and encountered strong resistance, leading to the policy failure of the privatization agenda.

Focusing on the psychological dimension and drawing on prospect theory and cognitive psychology, Weyland (2008) emphasizes the two main domains of interpretation – loss or gain – and how they shape policy change. Actors are in a domain of gain when they foresee a situation as having positive effects on them and in the domain of loss when they foresee a situation as having a detrimental impact on them. Following prospect theory, the psychological perspective argues that actors are usually risk averse in the domain of gain and risk accepting in the domain of loss. As Weyland (2008) argues, "people who face prospects of losses go to great lengths to avoid any costs, even if the chosen remedy holds considerable danger... When facing positive prospects, people tend to proceed with caution. They pursue gains with prudence and, due to loss aversion, refuse to incur risks for this purpose" (pp. 286-287). Thus, framing the status quo in the domain of loss is crucial for a radical policy change to occur.

Although they focus on economic policy reform, Haggard and Webb (1993) also provide additional strategies to complement my analytical framework. In their study, the

authors underline that while "policymakers undertaking economic reform rarely have much influence over the political structure or fundamental economic situation...they have considerable control over the design and tactics of reform" (p. 158). They itemize three main tactical and material approaches that design teams usually employ to shape policy change. These strategies relate to the tempo (i.e., whether reforms are introduced rapidly or not), sequence (whether they are introduced as a bundle or in a piecemeal) and remuneration (whether and how potential losers are remunerated). By referring to tempo, these scholars emphasize that policy change is usually more effective through a rapid approach, as it is more economical and has a tendency to generate more confidence for change relative to the delayed, slowed approach. As they point out, "delay has high economic costs and casts doubt on the sincerity of the reform effort" (Haggard & Webb, 1993, p. 158). They also note that the rapid approach is particularly important for a new government, as political support tends to peak at the beginning of every new government. As time goes on, however, the legitimacy of the government dwindles, making change difficult. Additionally, implementing reforms as quickly as possible allows the policy to more quickly develop a constituency for change. In particular, potential opponents may be taken by a surprise and hence unable to effectively organize against change. Introducing reforms quickly, therefore, can be a step towards ensuring successful reforms.

Regarding the sequence of reforms, Haggard and Webb (1993) argue that reforms are usually more successful when they are introduced in a single package rather than in a piecemeal. Different aspects of a reform may generate different outcomes – negative and positive – so introducing reforms in a bundle allows reformers to offset potentially “bitter” policies with “sweet” ones. If different aspects of a reform are implemented differently, specific opponents may emerge to forge a united front, which could cause the reform to backfire (Haggard & Webb, 1993). Finally, since they involve reallocation and redistribution of



resources, reforms are likely to create benefits for some stakeholders while making others suffer losses, even if not necessarily making them completely worse off. Therefore, to become successful, reformers must incorporate appropriate compensation packages for those who might suffer as a result of the reform. Compensations to potential losers would calm opposition and create a sound atmosphere for policy change (Bonoli, 2000).

Finally, in the case of Ghana, these strategies are complemented by the use of repression or force in some cases to smooth the policy process in its pursuit of path-departing policy change. Because Ghana has witnessed a number of military coups and authoritarian regimes since independence, studying the potential impact of repression on policy change is especially relevant.

### **2.3. Conclusion**

In the above discussion, I have argued that the functionalist, interest-based, institutionalist, globalization and partisan politics approaches to policy change are limited because they overemphasize the role of existing health care system, vested interests, veto points, imposition by international organizations and partisan effects, respectively. Hence, they cannot adequately explain the Ghanaian health policy changes, which depart significantly from the existing health care system and were pursued despite opposition from vested interests, ideological conflicts and opposition from key international actors.

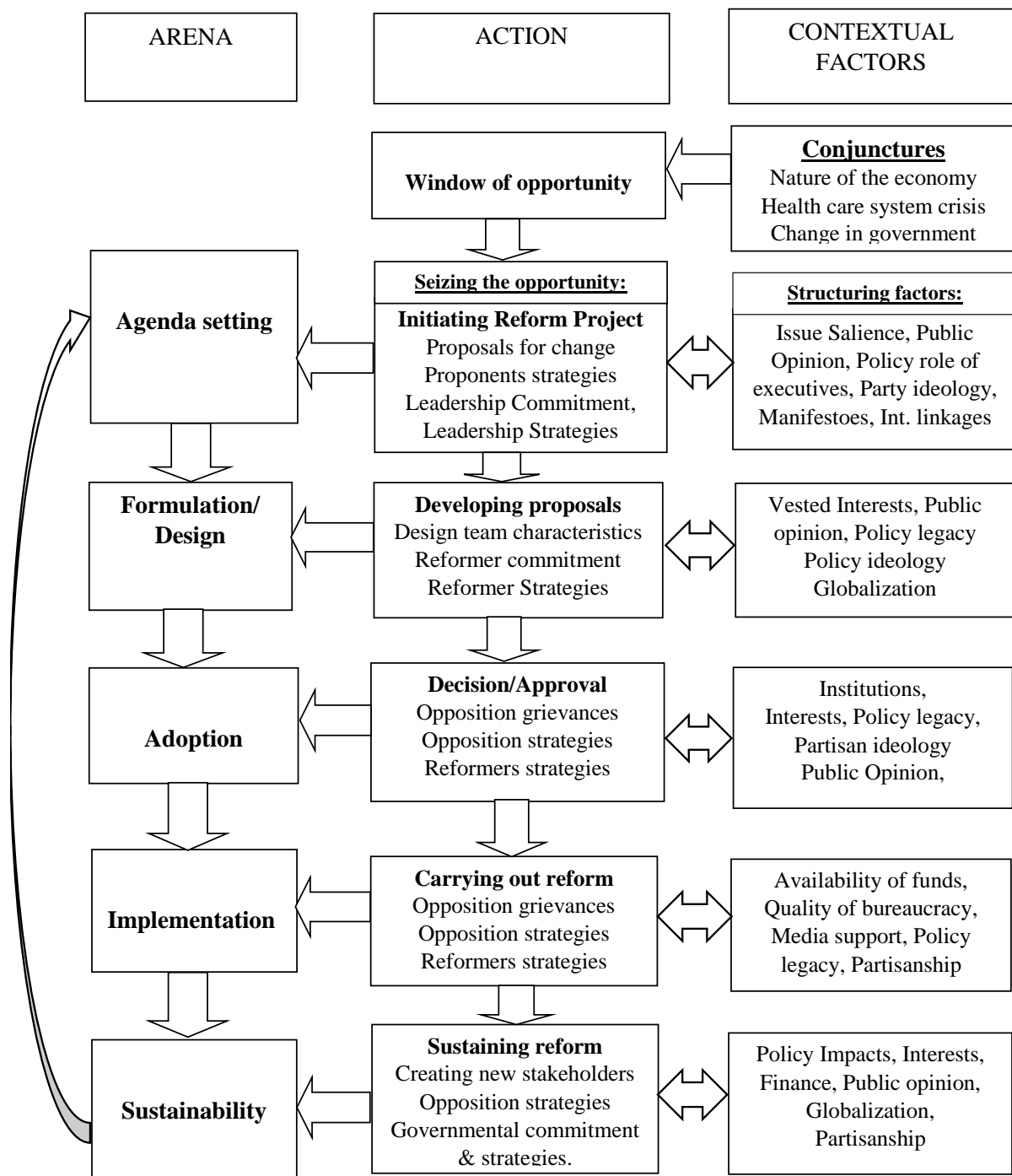


Figure 1 Summary of the theoretical framework of this study

Bringing agency front and centre while explaining the path-departing health care changes in Ghana, this study draws ideas from actor-centred institutionalism, particularly the

window of opportunity thesis, the policy as political process model and the ideational, as well as the incremental but cumulatively transformative strategies explained above. It complements these frameworks with the repressive strategies employed by reformers in Ghana, which are generally lacking in much of the dynamic institutionalist literature.

The Figure 2, above, illustrates the analytical framework of this study. In this framework, the state of the Ghanaian economy, coupled with the performance of the health care system and political transitions created windows of opportunity for change. Policy entrepreneurs then seized these opportunities and not only propelled the changes onto the agenda, but also saw them through design, approval, implementation and sustenance over time. The ability of policy entrepreneurs to go through the entire process successfully often depended on their commitment to reform and the strategies they employed, as well as the extent to which they were influenced by contextual factors such as institutions and policy legacies.

By placing policy entrepreneurs at the centre of policy change, however, this framework does not suggest that contextual factors have no effect on policy change. Rather, it shows that contextual forces such as political transition and ideology may create a window of opportunity for change or structure the behaviour of the policy entrepreneurs in their pursuit of policy change, respectively<sup>14</sup>. Thus, this study's analytical framework acknowledges situations whereby path-departing policy change may still occur despite the presence of contextual obstacles.

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<sup>14</sup> While it accommodates the window of opportunity thesis and the structuring impacts of contextual actors, the analytical framework of this study significantly disagrees with the strict deterministic argument that these necessarily determine the outcome of policy change.

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1. Introduction**

In order to arrive at an explanation that fits the reality of health policy change in Ghana, it was important to ground this study in a systematic discussion of the available research methods and techniques. This chapter, therefore, provides the methodological framework of the study: the research design, the methods and procedures of data collection and analysis, the justifications for employing those research approaches and methods, as well as the key challenges encountered in the research process and how they were surmounted. Before doing this, it is important to recognize that a number of research approaches have evolved in the social sciences with the goal of helping scholars to better study social phenomena. These approaches can be broadly categorized into qualitative, quantitative and mixed-methods. The quantitative approach involves the use of experimental design and statistics to establish relationships among specific social behaviours and variables. The qualitative approach, on the other hand, focuses on strategies that are unquantifiable, such as observations, document reviews and interviews to address social phenomena. Mixed-methods blend strategies from both quantitative and qualitative sources to understand social behaviour (Ritchie and Lewis, 2003).

Patton (1990) argues that whereas all the approaches are relevant, in order to attain the main goal of scientific inquiry, social scientists should pay primary attention to the "methodological appropriateness" of their study (quoted in Hoepfl, 1997, p. 48). In other words, the first and foremost priority should be how well the situation under investigation fits with the research approach chosen. For instance, based on the research problem, the purpose of the study and the research questions at hand, a particular type of research approach may appear the most useful (Patton, 1990; Hoepfl, 1997). Thus, none of the research approaches are universally superior to the others.

The qualitative approach was chosen for this study. The specific qualitative approaches employed involve a case study method, document reviews and semi-structured, in-depth interviews. This chapter provides details about each of these specific qualitative approaches and how they were employed. First, it discusses qualitative case study research method, focusing on its strengths and weaknesses and why it was the most appropriate approach for this study. Second, it explains the research design, beginning with a description of the research setting, particularly Ghana's health policy process and its geographical, demographic, political and economic history. Third, the methods and procedures of data collection and analysis are discussed. In the remaining sections, issues pertaining to ethics, the challenges encountered in the process of conducting the research and the measures taken to ensure the authenticity of the study's findings are also explained.

### **3.2. Qualitative Case Study Method**

George and Bennett (2005) define a qualitative case study method as a “detailed examination of an aspect of a historical episode to develop or test historical explanations that may be generalizable to other events” (p. 5). It helps to attain a detailed understanding within the framework of the actors involved (Ritchie & Lewis, 2003; Yin, 2003) and “provides tools for researchers to study complex phenomena within their contexts” (Baxter & Jack, 2008, p. 544). Kaplan and Maxwell (2003) emphasize that a qualitative case study approach is necessary where the causes of a situation are complex and for that matter no single variable can completely explain the observed outcome. This way, it “can yield theories and explanations of how and why processes, events and outcomes occur” (Kaplan and Maxwell, 2005, p. 33). Yin (2003) confirms the above argument, recommending the qualitative case study approach for scientific inquiry when the goal of the study is to address “why” and “how” questions, and

where contextual factors are critical for understanding the situation under study (see also Joia, 2002; Baxter & Jack, 2008).

The qualitative case study method is the most appropriate for this study given that I intend to attain a deeper understanding of the path-departing health policy changes in Ghana and, particularly, how and why they occurred within such a short period of time and despite the presence of factors (e.g. ideological conflicts and vested interests) that should theoretically prevent such outcomes. The use of this method in this research aided in uncovering the complexity inherent in policy change processes so as to devise a relevant explanation for why and how the changes occurred so quickly despite the countervailing factors.

Qualitative explanations involve exploring or establishing relationships or patterns of association in the data available, as well as interrogating why these patterns or relationships occur the way they do (Ritchie & Lewis, 2003). Kaplan and Maxwell (2005) emphasize that, "although experimental interventions can demonstrate that causal relationships exist, they are less useful in showing how causal processes work" compared to qualitative systems (p. 33). Qualitative researchers can formulate explanations using explicit reasons (e.g., participants' response to factors that motivate their actions); inferring an underlying logic in the data (by juxtaposing or interweaving noted and connectable themes); using a common sense assumption (i.e. patterns that are commonly known to exist or make sense); developing powerful analytical concepts (such as "social loss", or "normalization"); drawing on commonly known conclusions in the empirical literature; or using theoretical frameworks (Ritchie & Lewis, 2003, p. 261). In this study, the health policy changes in Ghana are explained by combining explicit reasons, logical inference, and theoretical frameworks, focusing on the dynamic institutionalist approach that was discussed in the preceding chapter. Qualitative description involves exploring the meanings and the experiences of people with the goal of obtaining a holistic and interconnected understanding (Ritchie & Lewis, 2003). Thus, in this study the causal

explanations and analysis of the health care changes in Ghana are made following a detailed description of the contexts in which the reforms took place.

Despite its relevance, the qualitative case study method is criticized for selection bias and lack of objectivity, reliability and validity (Ritchie & Lewis, 2003). However, as Ritchie and Lewis (2003) emphasize, much of these criticisms are the result of ineffective employment of qualitative method, rather than due to a limitation of the method itself. According to them, objectivity or validity and reliability “are important features of qualitative research, and attainable aspirations” (Ritchie & Lewis, 2003, p. 20). In order to promote the scientific basis of their studies, qualitative scholars must perform “internal checks on the quality of the data and its interpretation [as well as provide adequate] information about the research process” (Ritchie & Lewis, 2003, p. 272). Also, scholars should be reflexive in their approaches. That is, while they are responsible for structuring the direction of the entire research and data collection, scholars must ultimately ensure that the content of their studies truly reflect the viewpoints of research participants. This could be achieved by encouraging active involvement of research participants and ensuring that “participants covers the full range of dimensions, constituencies or groups which are of relevance to the research questions” (Ritchie & Lewis, 2003, p. 80). In analysing their data, scholars must also combine “creativity” with “systematic searching” and “inspiration” with “diligent detection” in order to ensure that scientific inquiry “is an inherent and ongoing part of ... [their] research” (Ritchie & Lewis, 2003, p. 199).

### **3.3. Description of the Research Site – Ghana**

The research was undertaken in Ghana, which is situated in West Africa, between latitudes 4° and 12°N and longitudes 4°W and 2°E. It shares borders with Togo to the East, Burkina Faso to the North, Cote d’Ivoire to the West, and the Gulf of Guinea to the South. The size of Ghana is about 238,533 square kilometres. The country is divided into ten main administrative

regions, which are further divided into metropolises, municipalities, districts, city, towns and villages. The main unit of local governance is the district. Currently, there are 216 districts. The capital city is Accra, which also doubles as the capital of the Greater Accra region. The latest population and housing census, which took place in 2010, pegs Ghana's population at 24,658,823. Of those, 48.7% are men and 51.3% are women (Ghana Statistical Service [GSS], 2012).

The country gained independence from Great Britain on the 6th of March, 1957, the first country in Sub-Saharan Africa (SSA) to have done so. It started off as a parliamentary democracy. The country, however, attained republican status in 1960 and transitioned into a presidential system, with Dr. Kwame Nkrumah as the first president. Later, the country went through a turbulent period from 1966 to 1992, characterized by an alternating military and civilian regimes. In 1992, a stable democratic system of government was finally restored. Having gone through six successive, peaceful elections since 1992, Ghana can be described as one of the few countries in Africa that has a sustainable democracy (Arthur, 2010). The consolidation of Ghana's democracy has also contributed to shaping the policy making process (Carroll & Ohemeng, 2012). For a long time, Ghana's policymaking process followed the bureaucratic model, where politicians and bureaucrats excluded the participation of other actors, as in many developing countries (Tsikata, 2001; Ohemeng & Ayee, 2012). With the development of a stable system of governance in Ghana, however, this has changed, paving way for many other actors, including civil society ones, to participate in the policy process (Ohemeng, 2005; Kpessa, 2009; Ohemeng & Ayee, 2012).

At the time of independence, Ghana's gross domestic product (GDP) was comparable to those of Malaysia and South Korea. Not too long after independence, however, Ghana's GDP fell (Werlin, 1994; Asare & Wong, 1999; Mazrui, 2006). Thus, whereas both Malaysia and South Korea have had a sustainable and growing middle-income economy for a very long



time (South Korea is now a high income country), Ghana had only moved from a lower income country to a lower middle income country in 2010/2011, a status it is struggling to maintain (Sakyi, 2011).

Ghana was chosen for this study because its experience addresses the main challenges identified in the existing literature on health care change: a failure to focus on path-departing health care change globally and in Low-Income Countries (LICs) in particular. Since Ghana pursued path-departing changes within a relatively short time frame, despite the influence of factors such as massive opposition from vested interests and the potential of ideological conflicts (Herbst, 1993; Coleman, 1997), it also provides useful information with which the existing literature on health care change, analyzed in Chapter Two, could be further interrogated.

In addition to being the first country in SSA to have attained independence, Ghana is representative of SSA, especially when the sub-region's recent political experiences are taken into consideration. For instance, it has experienced almost all the different political regimes that broadly characterize post-independence SSA history, including authoritarianism, a one-party system, a military takeover, and democracy. Focusing on Ghana, therefore, can serve as a point of comparison and an example for many countries in SSA and beyond. That said, Ghana's case is unique in a number of ways, including the rapid succession of radical health care reforms it witnessed in recent decades. This is partly why this thesis adopts a case study approach, which is best suited for the type of in-depth historical and political analysis undertaken here to explain policy stability and change over time.

### **3.4. Data Collection**

As indicated, two main sources of data were gathered for the study. They include document reviews and in-depth, semi-structured interviews. Document reviews involve studying existing

documents to “understand their substantive content or to illuminate deeper meanings which may be revealed by their style and coverage” (Ritchie & Lewis, 2003, p. 35). Document reviews are particularly relevant in studies where past events and experiences, communications and private and public records can help shed light on specific historical and political developments (Ritchie & Lewis, 2003). They are also relevant for studying situations where direct observations are impossible (Ritchie & Lewis, 2003). Since the situations under study involve particular events and processes that took place between the 1950s and 2000s, quite a number of studies had, indeed, been conducted on them. Hence, resorting to document reviews was found to be appropriate in providing a detailed and comprehensive understanding of the extent to which the literature on health care change explains the changes observed in this case.

In order to properly conceptualise the literature, existing studies were categorised into two groups. The first group encompassed the theoretical studies on policy change and, especially, on health care policy. I sought to familiarize myself with the different theoretical studies on health care stability and change so as to map out the key themes that could help guide my collection of empirical data on the health care systems and transitions in Ghana. The key themes that emerged during the review process of this set of literature were broadly discussed in Chapter Two. They include functionalism, interests, institutionalism, partisan politics and globalization.

The second set of documents I reviewed included existing materials on health care reforms in SSA in general, and Ghana in particular. They included relevant government documents, major Africa and Ghana newspapers, Presidents’ speeches and press releases, parliamentary records, NGOs’ reports, political party documents (manifestos and constitutions), reports of international organizations (World Bank, IMF, WHO, ILO), as well as relevant scholarly books and journal articles on the health policy process in Ghana. In reviewing these documents, my goal was to obtain a detailed understanding of the pattern and

politics of health policy change in Ghana, especially related to the three regimes of health care change in this study.

I reviewed this literature through the lenses of the broad perspectives identified in the theoretical literature and so was able to conceptualize the Ghanaian situation in relation to that theoretical literature. In turn, these conceptualizations helped in developing specific ideas to describe the Ghanaian situation. Some of these ideas are the imposition thesis, which emphasizes the disproportionate impact of global forces on health care change; the strong influence of institutions on policy change, including related to the colonial legacy; and the weak role of medical interests, particularly the medical association, in policy change. Other themes, such as economic crisis, political transition and political parties, were also identified. These ideas helped me formulate the research questions underlying this study, as well as the questions I explored during my fieldwork in Ghana. A review of the empirical literature also helped me uncover some of the key participants and stakeholders in the health care reforms under study. These actors were subsequently contacted during the fieldwork for face to face interviews.

Ofori-Birikorang (2009) stresses that relying solely on document reviews “might lead to a degree of subjectivity on the part of the researcher” (p. 98). It may also lead to ambiguous results (Kpessa, 2009). To limit these biases, the document reviews were coupled with in-depth, semi-structured interviews. Ritchie and Lewis (2003) define a semi-structured interview as a conversation between the researcher and the relevant stakeholders, whereby the former actively participates in the process with the aim of probing the latter for detailed information. Rightly so, this type of interview is sometimes referred to as a “conversation with a purpose” (Ritchie & Lewis, 2003, p. 138). Ofori-Birikorang (2009) declares that an interview is a “very rich source of data because the information provided is first hand, presumably accurate, and reveals the world of the participants, their emotions, and thoughts about the world around them” (p.

100). Interviews also provide an atmosphere that encourages social actors to tell their own stories regarding issues that affect them without interference. Thus, the semi-structured, in-depth interviews allowed me to unravel detailed information from the viewpoint of the relevant stakeholders I identified through the document reviews. It also allowed for flexibility, which, in turn, allowed me to seek further clarification from the research participants both prior to and after the interview process. By adding in-depth interviews to my research, I could also "explore all the factors that underpinned the participants' answers: reasons, opinion, and beliefs", thereby feeding the explanatory logic that underlies this study (Ritchie & Lewis, 2003, p. 141).

In all, I interviewed 35 participants for the study. These participants were recruited based on a stratified purposive sampling method. A stratified purposive sampling method involves selecting participants across relevant groups dealing with the same phenomenon; each group must be homogenous enough so that cross-group comparisons can be made (Ritchie & Lewis, 2003). In this regard, the sample was drawn from the main groups of stakeholders I identified through the document reviews as having been influential in the policy processes under investigation. These stakeholders include the media; cabinet ministers; officials in the Ministries of Health, Social Welfare and Finance; experts from the Ghana Health Service and the National Health Insurance Authority; parliamentarians and parliamentary staffers; members from civil society (the Trade Union Congress, the Ghana Medical Association, Help-Age and the Christian Health Association of Ghana); and foreign experts from the World Bank, Danish Development Assistance Programmes (DANIDA), International Labour Organisation (ILO), United Nations Development Program (UNDP) and World Health Organization (WHO)<sup>15</sup> (Zwi & Mills, 1995; Batley, 2004; Agyepong & Adjei, 2008).

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<sup>15</sup> The sample was distributed as follows: two media personnel; three cabinet ministers; seven officers from the Ministries of Health, Finance and Social Welfare; eight officers from the Ghana Health Service and National Health Insurance Authority; four parliamentarians and parliamentary staffers; nine people from the civil society sector; and five foreign experts. Three individuals belonged to two of the above classifications.

Ritchie and Lewis (2003) argue that once the relevant participants have been identified, the next step should be to develop a sample frame from which those people would be selected. The sample frame should be relevant to the research questions and allow the researcher to identify and make contact with relevant participants. The main sample frame for this study was organizational. The organizational sample frame involves recruiting participants for a study through the help of specific stakeholders or organizations that work with them (Ritchie & Lewis, 2003, p. 93). It is particularly useful for "generating a sample frame for a group which cannot be identified through official statistics or administrative records, and which are too scattered or small to be identified easily through a household screen" (Ritchie & Lewis, 2003, p. 93).

To identify the particular individuals that shaped the changes copies of the letters of recruitment, which had been approved by the Ethics Board of the University of Saskatchewan, were emailed to the relevant stakeholders at least two weeks to my travel to Ghana on the 3<sup>rd</sup> of March, 2013. In addition to making a formal request for participation in the study, the letters detailed the purpose and significance of the study, as well as the ethical measures underpinning it. Out of the over 20 letters submitted to various stakeholders through email, only three responses (from UNDP, DANIDA, and the African Women Leaders Network) were obtained prior to my travel to Ghana. Hence, after my arrival in Ghana, I visited the offices of these stakeholders to personally request their support in identifying individual participants for the study. This approach proved to be a more effective way of recruiting the participants compared to the email approach, especially since it allowed me to familiarize myself with some of the personnel of these organized stakeholders. Among all the stakeholder organizations that I visited during the participant recruitment process, the MoH was the most helpful; in addition to furnishing me with the list of potential participants, it also provided additional information related to other stakeholder organizations that participated in the reforms but were not

mentioned in the existing documents. These included the Department of Social Welfare within the Ministry of Employment and Social Welfare and the Social Security and National Insurance Trust (SSNIT).

A snowball method was added to the organizational sample frame to identify additional participants. A snowball method involves "finding research subjects, as one subject recommends another subject, who in turn refers another subject and so on" (Baidoo, 2009, p. 87). It is especially significant where participants involve a small population, are dispersed, and require a certain level of trust to participate. I added snowballing because the participants are largely elite, and many are in positions of power or even retired. Those in positions of power are usually busy and one generally requires protocols to be able to see them.

For participants in the 1980s reform, for instance, current officials were asked to refer people who were still alive and participated in the reforms. Unfortunately, none of those who had participated directly in the transition to the NHS system of the 1950s/1960s were alive to inform the study. However, some of the participants of the user fee and NHIS reforms provided useful information about the NHS that helped to complement the information obtained through the documents reviewed. A snowball method, however, may be challenged by the likelihood of participants recommending only like-minded people, such as friends, which could significantly skew the data (Ritchie & Lewis, 2003). In preventing this potential challenge, as Ritchie and Lewis (2003) suggest, I gave detailed information about the characteristics of the additional participants to the referrers. The referrers were then asked to indicate not only people who shared their ideas and preferences, but also those that opposed them during the reforms. That strategy allowed me to enlist divergent perspectives on the reforms, which also aided in limiting potential biases in the interview data.

All the interviews were conducted individually and in person. Individual participants were contacted directly by phone or through email, depending on the type of contact

information available. On my first contact with the participants, I introduced myself and explained the research agenda before requesting their participation in the study. This helped in creating a comfortable atmosphere and rapport during the interviews. When participants agreed to be interviewed, these were scheduled based on times and locations determined by the participants.

All the interviews were conducted in English, which is the official language of Ghana. English was chosen because all the participants understood and spoke it perfectly. Before starting each interview, the purpose and ethical procedures underlying the study were reiterated<sup>16</sup>. This allowed me to reassure the participants about ethical and confidentiality issues while focusing their attention on the topic of this study. Except for five longer interviews (between 1 and 3 hours), all the interviews lasted between 30 and 60 minutes, which is in line with the timeframe generally regarded as conducive for a lively interview (Ritchie & Lewis, 2003).

The five interviews that lasted longer than an hour did so because, based on the document reviews and stakeholder interactions, the participants were widely noted to have played extensive roles in the reforms under study. Hence, engaging them in a much more detailed discussion was critical to enrich the study. To allow these participants to prepare for the detailed discussion, however, both written and verbal permissions to that effect were sought during my initial contact with them. Fortunately, they all agreed to their interviews at least two weeks ahead of time, giving them the opportunity to adequately prepare. Coincidentally, all these interviews occurred on the weekends, when the participants were relatively free from official duties that could distract them. I took advantage of these opportunities to question these interviewees as much as I deemed relevant for the study.

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<sup>16</sup> Because the participants were all elites, they were also given hardcopies of the recruitment forms, which contain the purpose and ethical procedures of the study. They read and signed those forms before the interviews.

### **3.5. Research Instrument**

For the purpose of the in-depth interview process, I developed a semi-structured in-depth interview guide. The interview guide was prepared based on the relevant themes and issues identified through the document review. Some of the key themes explored during the interviews involved how the participants were connected to the health care reforms under study; their perceptions about how the ideas for change evolved and their role in the process; how the agenda for change was set, formulated, adopted, implemented and sustained; who were the key actors involved in the process of policy change and their positions on the reforms. I also interrogated how external actors, interests groups, partisanship, the state of the economy, public opinion and political transition shaped the reforms. Despite having these pre-set questions, I sought to remain flexible throughout the interview process. For instance, the original content of the interview guide was modified during the course of the interview process to make way for new information and additional insights. For instance, I incorporated the idea of strategic choice in the interview guide only after realizing their re-emergence in the responses of the first five interviewees. Also, while the questions on the interview guide were framed in general terms, I adapted them to suit the specific roles each participant played during the reforms under study. For example, the interviews for cabinet ministers and ministry officials focused to a large extent on how the idea for policy change emerged and what the process of formulating the reforms was like. The questions directed at front line bureaucrats, on the other hand, focused largely on implementation. Since the participants were very knowledgeable on a broad range of issues concerning the reforms, the interview guide protected me from straying from the substantive issues underlying the study.



For a number of reasons, including ethics and rapport<sup>17</sup>, I sought verbal and written permissions from the interviewees before each interview began. I used a tape recorder and a note pad to record the interviews. The note pad proved particularly useful in circumstances where the participants refused to be taped. Only three respondents refused to be recorded, indicating personal reasons. In these cases, I took detailed notes. Some of the interviews were transcribed into Microsoft Word documents immediately after they were conducted, but most of them were transcribed after the researcher had completed the entire interview process and returned to Canada. In all, the interview process ended in July 2013.

### **3.6. Data Analysis**

The data was analysed through content analysis and process-tracing techniques. Content analysis involves reviewing documents in order to understand and ascertain both their content and context. It involves identifying important themes in the documents, how the themes are being portrayed, and the number of times they appear (Ritchie & Lewis, 2003). As for process-tracing, it involves “trac[ing] the links between possible causes and observed outcomes” (George & Bennett, 2005, p. 6). Process tracing enables the researcher to examine documents or archives, interview transcripts and other data sources “to see whether the causal process a theory hypothesizes or implies in a case is in fact evident in the sequence and values of the intervening variables in that case” (George & Bennett, 2005, p. 6). Process-tracing is being used by a growing number of policy scholars. Campbell (2004) notes that ideational scholars can use process-tracing to study the impact of ideas on policy outcomes and to generate

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<sup>17</sup> Additional ways by which I built rapport with participants involved choosing appropriate dressing codes and communication skills. For example, since the research participants were mostly elite, I made sure that I put on a formal wear when going to conduct the interviews. I also used respectful language when addressing the interviewees. While it was enforced across the gender divide, use of respectful languages (such as “please,” “madam” or “sister”) was a special requirement when interviewing women, as Ghanaian women must, traditionally, be accorded much more respect than men.

hypotheses for future studies. Also, by using process-tracing, ideational scholars “can tell plausible stories about how, for instance, programs must fit into existing cognitive and normative constraints, and that if they don’t, then they are not likely to be effective” (Campbell, 2004, p. 119). In this study, the process-tracing approach allowed me to explore the sequence of events leading to the health care transitions under study. It also helped me assess the relevance of the various causal factors and how they interacted to shape the patterns of health care policy change in Ghana.

The computer program NVivo was used to analyse the interview data. Developed in 1999, NVivo has become a useful tool for qualitative research analysis (Bazeley & Jackson, 2013). It is able to organize and establish relationships in non-numerical or unstructured data. It can also perform coding and graphing, as well as store a significant amount of information, including pictures (Bazeley & Jackson, 2013). Thus, after transcribing the interview tapes into Microsoft word documents, I uploaded the transcribed data into the NVivo software. Thereafter, I coded the uploaded data into common themes that emerged from responses given by the interviewees and subsequently, along the broad perspectives identified through the document reviews. By organising these themes along the broad perspectives identified through the document reviews, I was able to conceptualize the Ghanaian situation in relation to the existing literature. This conceptualization shaped my analysis in Chapters 4, 5, and 6 as well as the choice of the conceptual framework underlying this study.

### **3.7. Validity/Trustworthy Concerns**

Measurements of integrity involve the researcher checking to see that the study is authentic. To enforce and protect the authenticity of the study's findings, therefore, I employed data triangulation and process and peer auditing, as well as asking the participants to review transcripts of their interviews. Triangulation is defined as “the use of different methods and

sources to check the integrity of, or extend, inferences drawn from the data” (Ritchie & Lewis, 2003, p. 43). By combining both document reviews and in-depth semi-structured interviews, I was able to juxtapose and compare the findings from each method. For example, the document reviews suggested that the user fee policy was externally imposed on Ghana. The information obtained through the interviews helped in understanding how that occurred. It indicated that although some direct external forces were involved, the reform process was largely driven locally. Juxtaposing these findings helped me to gain a more nuanced understanding of the factors that shaped policy change. To improve the validity of the study, the transcripts of the interviews were emailed to participants for verification. Participants were able to check their answers and correct any misconceptions that might have arisen during the interview and transcription process. Short phone conversations with some of the participants after the interviews (while in Ghana and after returning to Canada) also helped the researcher to seek clarification on complex issues as and when they emerged.

### **3.8. Ethical Concerns**

To address the ethical implication of the study, a copy of the research proposal, including the interview guide was, first, sent to the ethics committee of the University of Saskatchewan for approval. Having received ethics approval, I ensured that all ethical procedures were followed. These include protecting participants' confidentiality, anonymity and rights and freedoms. For instance, as indicated, interview dates and times were booked with participants ahead of time to accord them enough opportunity to prepare for, or decline, the interviews if necessary. Whatever information they provided was kept confidential except when the participants indicated otherwise. For this reason, the actual names of the participants, except those that indicated otherwise, were eliminated from this dissertation. In place of their actual names, pseudonyms are employed. I also made sure that participants were aware of their rights. At the

start of each interview, the participants were provided with and read copies of the ethical procedures underlying the study. The participants were also informed about their right to stop the interview if/when they deemed necessary.

### **3.9. Challenges and Solutions**

Most of the challenges I encountered during the data collection process related to the interview. For instance, though, the letters of recruitment were emailed to the relevant stakeholders about two weeks ahead of my travel to Ghana, responses to those emails were not forthcoming. As such, the participant recruitment process essentially began after I had arrived in Ghana. Additionally, although the participants were free to determine the date, venue and time they wished to be interviewed, some of them failed to show up as scheduled. Although the researcher managed to reschedule the meetings, this nevertheless led to a delay in the interview process. One of the relevant persons believed to have played a significant role in the transition to the health insurance process also refused to participate because he was too busy. However, he managed to direct me to a useful report he had compiled on the policy process. Additionally, as I mentioned above, none of the individuals who had participated in the NHS-type system directly were still alive. This was not unexpected given that the policy change had taken place about four decades ago. Also, some of the people who participated in the transition to the user fee policy directly were retired from the public sector, working in the private sector, or living abroad, making it difficult to identify them through the organizational sampling frame. However, I was able to identify and interview a significant number of them using the snowballing approach. To complement the information obtained from the direct participants in the reforms (and to ensure that enough relevant information was obtained for all the policy changes covered in this study), the definition of the relevant stakeholders was modified to include people who might not have played a direct role in the reforms, but were generally

referred by their organizations to have adequate knowledge on, and expertise in, the subject area. Interviewing those people proved useful as some of them had already done some work on the issues and eventually emerged as their organizations' mouthpiece on such matters.

### **3.10. Conclusion**

Given the complex nature of the topic of this study and its theoretical and explanatory intent, the qualitative case-study paradigm was identified as the most suitable for this research project. The qualitative case-study approach afforded me the opportunity to obtain a detailed understanding of how and why the changes occurred from the perspective of the relevant stakeholders and existing documents. The stakeholders include individuals and organizations that participated in the reforms directly and those that were not directly involved but believed to possess adequate information on, and expertise in, the issue area. By focusing on perspectives from both sources, I was able to establish triangulation, which helped to improve the validity of the study.

The next three chapters explore the main health care regimes in Ghana since independence. Beyond assessing the scope of these changes, the chapters also provide an understanding of the various points of continuity, suggesting that the path-dependence thesis might not be debunked even in the context of radical policy changes.

## **CHAPTER FOUR**

### **THE DEVELOPMENT OF A NATIONAL HEALTH SERVICE IN GHANA**

#### **4.1. Introduction**

Upon attaining political independence on March 6, 1957, Ghanaians were imbued with hope of a prosperous and buoyant future. As a popular saying by Dr. Kwame Nkrumah, the first president of Ghana, suggests, (“seek ye first the political kingdom and liberty and all other things shall be added unto it” [Timothy, 1963, p. 130]), people expected independence to put an end to the challenges associated with colonialism in Ghana. In the health sector, those challenges included a health care system that was exorbitantly expensive for patients, discriminatory against natives, urban-biased, significantly underdeveloped and woefully inadequate (Twumasi, 1981). To improve health care for all Ghanaians, the government decided to introduce far-reaching policies such as abolishing health care user fees and establishing more health care facilities (Senah, 2001). Consequently, by 1962, Ghana’s health system had become very much like the British NHS that offered universal health care to all residents.

This chapter examines the process of transitioning from the minimalist approach to health care provided under the colonial system to the universal NHS-style health system after independence. Considering the political and the technocratic factors that influenced the change, it is clear that various factors interacted in both complex and dynamic ways to bring about comprehensive change to NHS. These factors include: (a) the poor and discriminatory state of the Ghana’s health system at the time; (b) the transition towards self-government; (c) the election of a socialist and nationalist leader, Dr. Kwame Nkrumah, whose ideological affinity with the policy change was crucial; (d) the economic and human resource vibrancy of Ghana, which meant that the necessary resources for pursuing the change were available; (e) the global trend towards big government, including the diffusion of the idea of the British NHS;

(f) the concentrated institutional configuration of Ghana's legislature that, in turn, limited the veto points for potential sabotage by interests; and (g) policy entrepreneurship by the Maude Commission, which pushed the policy change onto the agenda, President Nkrumah, who led the entire reform process and Dr. Brachott's design team and other actors, who supervised the adoption, implementation and sustenance of the policy change overtime.

For the sake of simplicity, the above factors are classified into three categories: conjunctural factors or windows of opportunity, policy entrepreneurship and institutions. For instance, conjunctural factors such as the deplorable state of the health care system, the transition towards self-government, the election of a socialist leader, the international drive towards welfare state expansion and the growing Ghanaian economy created windows of opportunity for change. Various policy entrepreneurs then seized the opportunities to bring about policy change within Ghana's favourable institutional context. For example, the new government (led by Nkrumah) set up the Maude Commission to study the health care situation in the country and make recommendations for policy change. Based on its findings, the Commission then put the NHS-type system on the agenda, a system that was ultimately designed by Dr. Brachott. In turn, the adoption process was facilitated by the socialist and nationalist orientations of the government, as well as, the commitment and strategies of the Nkrumah government, while the implementation process was facilitated by the quality of Ghana's bureaucracy and the political strategies of President Nkrumah. Sustaining the policy change over time was also largely the result of the high political commitment and strategies of the government, including President Nkrumah, as well as, the policy's ability to generate a large constituency, which guarded against its reversal even after the overthrow of the president. Finally, the policy change was facilitated by the institutional configuration of Ghana, which was made up of a unitary system and an executive-centered legislative assembly that was dominated by the members of the ruling party.

In the sections that follow, the transition to the NHS-type system is explored. The first section focuses on the evolution of health care change in post-independence Ghana, accounting for its main components, content, actors and timing. The second examines the magnitude of the change. The third section explores why and how the transition occurred, using analysed data mostly from the document reviews,<sup>18</sup> while the fourth explores the interactive mechanisms at work and shows how various causal factors interlaced over time. The next section analyses the findings based on the theory of dynamic or actor-centred institutionalism, while the final section provides a concluding remark for the chapter.

## **4.2. The Evolution of NHS in Ghana**

In the early part of the colonial period, modern health care, though important, was not a topical issue on the policy agenda (Brenya & Adu-Gyamfi, 2014). The fundamental reason, as Senah (2001) indicated, was that a majority of the population were not in tune with the modern or allopathic health system. They believed that it had been brought along by the Europeans who came to trade and eventually settled in the country. Ordinary Ghanaians were used to their indigenous health system because it was the only system familiar to them. Beyond that, it was (and still is) rooted in their culture and applies principles of healing that resonate well with their understanding of health care (Twumasi, 1981). As such, they held a strong belief that indigenous health care was a precious inheritance from their ancestors that must be protected and upheld (Twumasi, 1981). In contrast, the allopathic health system applied healing principles to which people could hardly relate. The fact that, when it was first introduced, modern health care was concentrated in the colonial posts such as castles and forts that mainly

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<sup>18</sup> The analysis in this chapter is based mainly on document review because, as suggested, the potential respondents were not alive to inform the study through semi-structured, in-depth interviews.



benefited Europeans rather than the entire population of Ghana likely convinced few of the benefits of modern health care (Arhinful, 2003).

However, due to the Europeans' extensive communication and interaction with the natives in the 19<sup>th</sup> century, largely as a result of extensive European missionary activities and businesses in the hinterlands, the colonial administration decided to extend some modern health care to Ghanaians. The initial attempt included Ghanaians who were working in the colonial civil service, the military, and the mining sector (Baidoo, 2009). The inclusion project led to a concentration of most health care facilities in the colony and urban areas where most Europeans and civil servants lived, and so also contributed to the neglect of the hinterlands (Twumasi, 1981). For instance, out of the 39 hospitals reported in colonial Ghana in 1927/28, about 72% were stationed in the colony, while the rest were shared by those in the hinterland - the Ashanti (15%) and the Northern (13%) regions (Patterson, 1981). This situation, among others<sup>19</sup>, directly contributed to the poor health conditions in the hinterlands, where a majority of the Ghanaian population lived (Baidoo, 2009). Thus, it was not surprising that only about 10% of the population could access medical care during the colonial era (Senah, 2001). Indeed, the figure might have been even lower; many of the natives (mostly official workers) who visited the health centres in the colonial era may have done so for the associated benefits (e.g., work leave, etc.) rather than to seek medical treatment (Twumasi, 1981; Senah, 2001).

In 1852, the colonial authorities, with the consent of some colonial chiefs, introduced a Poll Tax in an attempt to increase natives' enrolment in the health system (Arhinful, 2003). The philosophy behind its introduction was that "if the Gold Coasters [Ghanaians] needed health care they would have to pay for it" through a head tax (Arhinful, 2003, p. 33). The tax was supposed to generate additional revenues to support the national economy, but it was also

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<sup>19</sup> Also, "trypanosomiasis found in Ashanti and Northern region were not viewed as a threat to the colony; therefore, the colonial authorities and medical practitioners diverted their focus away from containing the disease and even suspended tsetse investigation between 1918 and 1923" (Baidoo, 2009, p. 34).

meant to make medical care free of charge (Arhinful, 2003). However, the policy failed, leading to the institution of user fees (Arhinful, 2003). Thus, whereas Europeans and Africans who worked for either the colonial government or businesses owned by Europeans, particularly the mines, were provided free medical care services, ordinary Ghanaians were paying for those services. Although they seemed small, the user fees proved expensive enough to discourage natives from accessing medical care (Baidoo, 2009). This was particularly true because, as Arhinful (2003) notes, fees were computed on the basis of the actual cost of service, plus 15% in additional charges to cover overhead costs. In this context, as Baidoo (2009) described, “native accessibility to the...health system became a sign of affluence to which many citizens aspired” (p. 33).

By 1951, when the longstanding struggle for internal self-rule intensified, a majority of Ghanaians had grown receptive to modern health care for reasons that included its earlier success in treating contagious diseases such as yaws and small pox (Arhinful, 2003). Nevertheless, the health sector still faced deep challenges. It was, for example, largely focused on curative care, neglecting preventive services (Baidoo, 2009). According to Arhinful (2003), while there were three rural health centres by the time Ghana attained internal self-rule in 1951, there was still no preventive health care in Ghana.

When Kwame Nkrumah assumed office as prime minister in 1951, he decided to pay particular attention to the health sector. First, he converted the colonial Health Department into a MoH, which was to be headed by an African. Second, he set up teams of experts whose aim was to study the health care situation in the country and make recommendation for change. The government also established the University of Ghana medical school with the goal of providing free medical training to Ghanaians. It also enlarged and improved the Korle Bu Teaching Hospital, originally set up by the colonial governor, F. G. Guggisberg, in the 1920s (Senah, 2001). The government also sought to address the problem of unequal distribution of health

service in the country (Akazili, 2010). Hence, several health care centres were established across the country (Senah, 2001; Wireko & Béland, 2013). Furthermore, the government allocated significant funding for the health sector. For example, about 31% of the total budgeted expenditure (amounting to 144 million pounds) in the 1963/1964 fiscal year was voted for the development of social services, including health care (Senah, 2001). Surprisingly, this occurred at a time when the price of cocoa, the country's major foreign exchange earner, was falling in the international market (Senah, 2001).

From 1964 onwards, these changes began to have a significant impact on the Ghanaian economy. Particularly, the revenue capacity of the state had plummeted significantly (Senah, 2001). While the government introduced some measures to address the situation, including foreign exchange and import restrictions, they failed to save the health sector. Rather, those measures adversely affected the importation of capital intensive equipment, drugs and supplies for the health sector (Arhinful, 2003). This situation upset personnel in the health sector and made them critical of the government and its policies (Arhinful, 2003). It also generated opposition from political activists. For instance, in view of the deteriorating socio-economic situation, a group of military personnel, referring to themselves as the National Liberation Council (NLC), overthrew the government in 1969.

### **4.3. Examining the Change**

As suggested in Chapter One, the magnitude of change in health policy is examined based on both spending (quantitative) and institutional (qualitative) changes in the health care system resulting from the establishment of NHS in Ghana. Using the above criteria, significant changes were observed in both public spending on and the institutionalization of health care after the introduction of the NHS system. The policy change led to both a rise in the amount of government spending on health care and an expansion in the structure of that spending. For

instance, it created a shift from private to public provisioning of health care; from a health system with fee payment as the main criterion of access to one that focused on citizenship; from a system that capped benefits to one that emphasized comprehensive benefits; and from one that targeted Europeans to one that emphasized universal access to health care for all residents.

#### **4.3.1. Spending Change**

Government spending on health care improved significantly after the introduction of NHS (Arhinful, 2003; NDPC, 2005; WHO, 2006)<sup>20</sup>. For instance, as Grischow (2011) noted, the government spent not less than 63% of the total budget on social services and infrastructure, including health care, between 1957 and 1966. Between 1960 and 1961 government expenditure on health care doubled from that of the 1957-1960 period and tripled for the period of 1961-1962 (Addae, 1996). As well, the government allocated about 53 million pounds sterling over ten years to its development agenda, which included the NHS (Addae, 1996). According to Baidoo (2009), total government expenditure in the health sector increased from 6.4% to 8.5% between 1965 and 1969; generally, “the government spent more on health care and human resource development compared to other departments” (p. 41).

Beyond the increase in government expenditure, the introduction of NHS also resulted in changes to the structure of government spending on health care. For instance, the government focused much of its health care expenditure on a radical expansion of the number of health care facilities in the country (Twumasi, 1981). For example, the number of health centres rose from 10 to 41 between 1957 and 1963 (Senah, 2001). In the end, because it outlawed the colonial fee-paying system that required ordinary Ghanaians to pay at the point

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<sup>20</sup> While these studies acknowledge the increase in public spending after the introduction of the NHS system, none of them provide information about the quantum of increase

of service use, under NHS, the government became the only payer of medical care in the country through general revenues.

#### **4.3.2. Institutional Change**

Policy change also led to a shift from a health care system that targeted colonial Europeans to one that provided universal access to health care for all residents of Ghana, including foreigners. Health care services were provided free of charge at the point of use. The free provision of medical care made access to care a fundamental human right, thereby eliminating the need for individuals to resort to the market for those services. For a number of reasons, which are explained below, the government also emerged as the sole provider of medical care in the country. Hence, it could be argued that the creation of the NHS system also resulted in a transfer of medical power from the market to the state.

Arhinful (2003) notes that under the colonial health system, “higher income workers were expected to pay when they exceeded their limit within which free care was provided” (p. 36). For example, government workers who exceeded their limit for free services were required to pay between 3 shillings 6 pence per day (if their earnings exceeded 250 pounds) and 6 pence (if their income was below 50 pounds) to cover themselves, their wives and their children (Arhinful, 2003). The NHS abandoned the cap system and replaced it with comprehensive medical coverage, which encompassed outpatient and in-patient care, dentistry and medication, as well as all diseases (Arhinful, 2003).

In part because it was free, the NHS also created a higher level of access to health care compared to the colonial health system (Baidoo, 2009). For example, the rise in the number of available health care posts recorded a tremendous increase in use under the NHS system (Arhinful, 2003). Public confidence in modern health care had also drastically improved by the

time of independence (Arhinful, 2003), which could also have helped create a higher demand for health care under the NHS system.

A recent comment by Dr. Vladimir Antwi-Danso, an adherent of Dr. Nkrumah and Senior Research Fellow at the Legon Centre for International Affairs and Diplomacy (LECIAD) that “one of the best interventions we have as a country is pregnant women going to hospital for free, the poor also getting medical care for free,” (TV3 Weekend News, March 1, 2013<sup>21</sup>) confirms the extent to which the NHS system guaranteed the social rights and freedom of the individual. For the reasons mentioned above, this study argues that the establishment of NHS led to a significant change in health care policy in Ghana. There were some important areas of continuity, however. For example, although the NHS system led to an increased medical care infrastructure, the majority of the infrastructure were located in the urban areas. This situation perpetuated the rural-urban inequity in access to medical care, which was a key feature of the colonial health care system. Despite the continuity in this feature, the changes that were introduced by the new system were significant. In the following section, I explain how and why the NHS system was achieved.

#### **4. 4. Why and How the NHS was Pursued**

This section explains the transition to NHS, from agenda setting to policy formulation or design, adoption, implementation and sustainability, accounting for both the political and the technocratic dimensions of health care system change in the process.

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<sup>21</sup> Retrieved from <http://tv3network.com/all-news/politics/local/best-social-interventions-in-ghana-have-been-under-nkrumah-and-kufuor-antwi-danso.html>

#### **4.4.1. Problem Definition and Agenda setting**

The high costs of medical care for the public and the health system's overall discrimination against Ghanaians became a great cause of concern to most stakeholders in colonial society, including colonial and African elites. Akosa<sup>22</sup> (2013) described the nature of the colonial system in his interview. He noted, "it was a system that served the British and London as a metropolis. It was a system that did not serve the Ghanaian people, the only hospital that was built for Ghanaians was Korle-bu hospital at that time, so throughout the whole land there was virtually no health facility that indigenes could go to". He emphasized that, "if you were an indigene and you went there, you paid through your nose because the whole essence was not to make you come [or seek medical care]. So as indigenes, really, there was no health facility at all and people of course resorted to what you will say is an indigenous health system, that is herbal and traditional medicine".

Situations like this created a need for reform, particularly the removal of user fees. The first time such a policy idea came on the agenda was in the 1850s, when Governor Stephen J. Hill (1851-1853), in consultation with some Fanti chiefs, introduced a one shilling Poll Tax for all residents in the colony. As indicated, the tax was supposed to grant all people in the colony free access to basic health care services. However, it was withdrawn in response to public resistance, leading to the concurrent withdrawal of the free medical system in just a few years (Arhinful, 2003). After that, the idea of universal medical care vanished from the policy agenda. Its disappearance, however, was not much of a surprise because most of the population had not become accustomed to the modern health care system (Arhinful, 2003). Also, as indicated, the few available hospitals were concentrated in the colony and a few others places, where only Europeans and colonial officers lived (Twumasi, 1981; Senah, 2001).

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<sup>22</sup> Akosa is a former Director General of the Ghana Health Service (GHS) and the president of the Ghana Medical Association (1999-2001). He is currently, the spokesperson on health for the CPP, the party of the first president of Ghana (Nkrumah).

However, by the 1950s, the colonial-based medical care system had gained a marked popularity among the natives, even though it was still discriminatory and expensive (Arhinful, 2003). That situation, among others, intensified the longstanding struggle for self-government by the natives. In 1951, the British finally agreed to grant self-government to the Ghanaians. They first organized an election for internal self-government, which was contested by the two main political groupings in the country at the time – the United Gold Coast Convention (UGCC), led by Dr. J. B. Danquah, and the Convention People Party (CPP), led by Dr. Kwame Nkrumah (Biney, 2011). These political parties were divided on ideological and class lines. The former was largely comprised of Ghanaian elites, such as lawyers and businessmen, who subscribed to rightist ideological orientation, while the latter was mainly made up of ordinary people on the street, workers, and students etc., who were on the left of the political spectrum. The two groups were also divided on perceptions about independence, as their mottos, "Independence in the shortest possible time" and "Independence Now", respectively, indicate. The UGCC also appeared less aggressive in its quest for self-government compared to the CPP, which was extremely radical. In the end, the CPP won the 1951 election with 34 out of 38 seats in the legislative assembly and 82% of the popular vote, automatically making the party's leader, Nkrumah, who was then in prison, the Prime Minister of the country (Okoth, 2006).

Given that he had won the election with such an overwhelming majority and was the first African Prime Minister of the country, Dr. Kwame Nkrumah saw the period as a window of opportunity to pursue change. Akosa (2013) explains this more.

Of course you had Kwame Nkrumah leading the independence movement. His own ethos was to decolonize Ghana. Therefore, everything that was to the colonial advantage had to be reversed and, in 1951, when he became leader of government business, the first thing he did was to advocate for free health, free education. It was the goal of these two major social interventions to ensure that everybody born to this country would have good health or at least access to good health and good education. And therefore, you could imagine that infrastructure had to be built because there was none, for over hundred years I said there was only one hospital built in Accra every hospital that was available was a European hospital.



The 1951 election was a crucial moment for policy change because, until that period, Ghana had been ruled by the British through a governor who acted as the official representative of the Queen of England. Nkrumah used the opportunity to explore making changes to the NHS system. He set up a commission of inquiry, led by Sir John Maude, a former permanent secretary of the MoH in the UK, to review the health system and make recommendations for policy change. Named after its leader, the commission was simply referred to as the Maude Commission. According to Arhinful (2003), the mandate of the commission was:

To review the measures taken and projected in the Gold Coast, either by government or by enterprise; for the development of preventive and social medicine, including health education; for the development of curative medicine, including the provisions for hospitals, health centres and dressing stations and for the training of personnel; for medical research; to examine the adequacy of the administrative structure and organisation of the Medical Department in relation to such development; and to make recommendations (p. 45).

From the above quote, it is clear that establishing the NHS was not directly touched upon in the commission's mandate, though it featured prominently in its report. As Arhinful (2003) noted, the commission recommended, among other things: (a) the abolition of hospital fees and all charges; (b) the establishment of additional health care facilities, mostly health centres and dressing stations; (c) the division of health care management between the central government and local government units, whereby the former would take over hospitals and health centres, while the latter would take control of dressing stations and maternity homes; (d) the need to let large municipalities recruit their own MoH staff and operate health services in schools; and (e) the need to place rural and urban sanitation in the hands of urban and district councils (Arhinful, 2003). By suggesting free medical care and an expansion of medical care facilities in the country, the Maude Commission could be regarded as the first to have put NHS on the agenda of post-independent Ghana.

After self-government was achieved, the agenda for change to the NHS can also be understood in the context of domestic need, the nature of the economy at the time and the diffusion of the British NHS. Addae (1996) argues that in fulfilling their responsibilities, the

members of the Maude Commission travelled across the country to solicit views on the health problems the people faced and possible solutions. It also advertised the process in the media and solicited suggestions, memoranda and letters from various stakeholders. As Addae (1996) notes, “the enquiry was the most exhaustive study on medical matters ever undertaken in the colony’s history” (p. 84). Since they emerged from this general inquiry, the Commission’s recommendations can be interpreted as being the popular opinion of the people.

Ghana’s economy was growing rapidly at the time (Senah, 2001), which also influenced the agenda for change. As Addae (1996) emphasized, “in view of the financial circumstance of the country to which their attention was drawn right at the onset of their enquiries, the commission recommended that the urgent medical needs of Ghana could be met by the expansion of the Medical Field Units, improvement of hospital facilities, the setting of health centres” (pp. 84-85). Thus, the importance of the vibrancy of the Ghanaian economy to the agenda of establishing NHS cannot be overemphasized.

Another important factor in these developments is the creation of the NHS in the UK in 1948, just three years before the 1951 elections in Ghana. Maude and two other members of the Ghanaian commission, Dr. Albert Lorenzen and Dr. George Albert Clarke, were British (Addae, 1996) and quite familiar with the NHS reform in the UK. It should also be expected that their knowledge of the popular British NHS system would influence the Commission’s recommendations. One of the key features of the British model that relate to the Commission’s recommendation is its focus on providing free care to all residents (Arhinful, 2003). According to Arhinful (2003), Nkrumah approved the Commission’s recommendations as the basis for broad reforms to be pursued after 1957, when independence was officially granted.

The NHS system got onto the policy agenda, therefore, as a result of the interaction between a window of opportunity (created by five main conjunctural factors) and the role of policy entrepreneurs such as Dr. Nkrumah and members of the Maude Commission. The

conjunctural factors involved the discriminatory and expensive nature of the health care system prior to independence; the political transition away from British rule, which began with internal self-government in 1951; the election of a socialist and nationalist government led by Dr. Kwame Nkrumah; the vibrant economic position of the country in the 1950s; and international influences with respect to the turn to welfare state expansion and, particularly, the diffusion of the idea of the British NHS across the world at the time. The above factors created a window of opportunity, which the policy entrepreneurs mentioned above seized. While all the above factors contributed to shape the policy agenda, the most central factor was the report of the Maude Commission. In this respect, how the commission managed to make its proposal appealing to the government (including using public inquiry) was critical to the push to establish a NHS in Ghana.

#### **4.4.2. Formulation/Design**

One of the important things Nkrumah did upon winning the 1957 election was to pursue the agenda the Maude Commission had set (Coleman, 2011). In order to develop a policy framework to guide the process, he recruited Dr. David Brachott, who was a member of the medical assistance group that had been sent from Israel to Ghana at the time. His main task was to help reinvent Ghana's health sector and to develop a ten-year medical policy for the country. As Coleman noted (2011),

The ten-year health service development program sought to deal with three major aspects of providing health care: a rural health service integrated into the system of hospitals, health centers, and other medical units; a country wide hospital plan based on the health care needs of the population and on sound medical and economic consideration; and a training program for medical and paramedical personnel capable of achieving the ten-year health program goals (pp. 10-11).

The ten-year medical plan was incorporated into the nation's ten-year development plan. As indicated above, it sought to increase the number of health facilities in the country and make services in those facilities free. In addition to the above, it banned private practices and

prohibited government doctors, dentists and specialists from charging fees. Finally, outpatient care was made entirely free for all residents, while a small charge was instituted for in-patient care with respect to civil servants and the military (Coleman, 2011; Arhinful, 2003).

Like the Maude Commission's report, the country's medical policy should be viewed in light of both domestic and international influences. For instance, Dr. Brachott, who was basically a "one-man team," decided to travel around the country in order to incorporate local ideas into the new policy (Addae, 1996, p. 91). It is also possible to see the influences of the recommendations of the Maude Commission in the new medical policy. For example, like the Maude Commission's report, the design also placed a ban on user fees and the privatization of medical care. Given the source of its mandate, it is normal to expect that the design would be influenced by the socialist orientation of the government at the time. As a high level bureaucrat and professor of public health (Addae, 1996), Dr. Brachott was also abreast of global social policy trends, and the idea of the NHS system. Thus, in designing the Ghanaian NHS system, he must have also drawn lessons from abroad, particularly, from the design of the British NHS system.

#### **4.4.3. Adoption of the Policy**

The adoption of the NHS was shaped by the policy entrepreneurship of Nkrumah and other political and economic considerations. First, Nkrumah's Convention Peoples Party (CPP) had the majority of seats in the party-disciplined Legislative Assembly, which facilitated the adoption of the policy (Botwe-Asamoah, 2005; Biney, 2011). Besides the legislative influence, the NHS was aligned with the ideology and philosophy of President Nkrumah and the CPP. These beliefs and ideology are laid out by Nkrumah in his *Autobiography*. As he explains,

The ideology of my Party may be formulated as follows: no race, no people, no nation can exist freely and be respected at home and abroad without political freedom. Once this freedom is gained, a greater task comes into view. All dependent territories are backward in education, in agriculture and industry. The economic independence that

should follow and maintain political independence demands every effort from the people, a total mobilisation of brain and manpower resources. What other countries have taken three hundred years or more to achieve, a once dependent territory must try to accomplish in a generation if it is to survive. Unless it is, as it were, 'jet-propelled', it will lag behind and thus risk everything for which it has fought. Capitalism is too complicated a system for a newly independent nation. Hence the need for a socialistic society (Nkrumah, 1957, p. x; also quoted in Biney, 2011, p. 106).

Nkrumah's beliefs and ideology can be described in three ways, which are all aligned with the principles of the NHS system. They are anti-colonialism, independence, and socialism. As Botwe-Asamoah (2005) notes, Nkrumah was not just sympathetic to socialism, but also a strong advocate. For Nkrumah, as one interviewee noted, "to compromise on ideology is abandoning it" (Akosa, 2013); socialism was seen as the most effective way for the newly independent country to tackle the remnants of colonialism, which were typically capitalistic (Afari-Gyan, 1991, p. 167). However, Nkrumah "cautioned against an uncritical adoption of socialism pursued elsewhere" rather than an "African [or scientific] socialism", which is based on the specific circumstances and conditions within which a country finds itself (Afari-Gyan, 1991, p. 169). Nkrumah's second reason for adopting socialism was that it was the only known alternative to capitalism. According to President Nkrumah, capitalism was too complicated for a newly independent country like Ghana to adopt (Nkrumah, 1957). The complications of capitalism revolved around its overwhelming emphasis on growth, and the subsequent neglect of equity. Finally, unlike capitalism, he believed that socialism promoted equity and solidarity, which are fundamental to African society and development (Botwe-Asamoah, 2005).

Thus, Nkrumah had no problem approving the design of the NHS system because it fitted perfectly with all the three dimensions of his beliefs and ideology. It also symbolized a break with the colonial market-based past and reinforced the African culture of redistribution and solidarity. As a newly independent state, the NHS also measured up to the expectations of the general populace that the independence would result in a better life generally and, by extension, an improved access to health care for all Ghanaians (Coleman, 2011).

In part because of the expectations it raised, the adoption of the NHS system met severe challenges. In other words, as Adibo (2013)<sup>23</sup> stressed during the interview, “it was tough”. For instance, it met a “stiff opposition from health care providers” (Coleman, 1997, par. 12). Indeed, a reaction of that nature should be expected in view of the fact that until then health care was a huge source of revenue for both public and private health care operators in the country. As Arhinful (2003) indicated, “private patients seeking treatment in a government hospital was liable to pay: a private professional fees, a statutory dispensary fees and the cost of any medication prescribed” (p. 46). The colonial government also allowed specialists to privatize their services so that even in government health facilities, ordinary or nonofficial Ghanaians paid them for their services (Arhinful, 2003). As Arhinful (2003) noted, “some of the professional fees paid ranged between 2 shillings and 5 shillings for brief outpatient visit to medical officers, while outpatient visits to a physicians or surgical specialist cost two pounds two shillings” (p. 44). Since all those charges were going to be forfeited as a result of the introduction of NHS, it is not unexpected that provider doctors would oppose the policy.

Mission or religious-based providers (RBP) were also to be affected by the introduction of the NHS system. Mission hospitals began in Ghana in the 1930s with the establishment of the Agogo hospital in the Ashanti Akim district of the Ashanti Region and developed into the second largest providers of health care in the country. According to Arhinful (2003) between 1951 and 1960, the number of mission hospitals grew nine fold, from 3 to 27. These hospitals held significant political power when the NHS system was introduced because they mostly operated in the hinterland where the colonial health system was largely deserted, although the majority of the Ghanaian population lived in these areas. Their mode of operation and

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<sup>23</sup> Adibo is a public health specialist. He was the head of the Planning and Policy Unit of the Ministry of Health in the 1970s and early 1980s before appointed the Director of Medical Services in 1986 and subsequently, the Deputy Minister of Health. He was a key architect of the Ghana user fee model and many other health sector reforms such as the Ghana National TB Control Program in the 1960s.

financing, as Arhinful (2003) indicates in the passage below, also suggested that they would be a critical force to consider in instituting the NHS-type system. For instance, as he notes,

One remarkable aspect about the mission facilities, as far as health financing is concerned, has been that the collection of user fees had always been part of their operations. No common fee schedule exists as such, and user prices might vary from mission to mission and from Church denomination to denomination; but some mechanism exists by which fees are matched with the costs of the services provided. Such charges usually covered recurrent expenditures; the full cost of drugs was passed on to users (Arhinful, 2003, p.48).

Given their huge size and strategic areas of operation, coupled with the fact that user fees were a huge part of their operations, as suggested in the above passage, the mission hospitals were undoubtedly important political forces to reckon with in the introduction of the NHS system.

In order to obtain the support of the medical doctors and the mission hospitals, the government decided to compensate them for their work. For example, as Adibo (2013) noted during the interview, the “mission hospitals that were charging fees for their services were reimbursed for the services they provided to the various categories of people”, while “doctors [were given] allowances in lieu of private practice”. In this respect, the annual allowances and reimbursements were utilized as strategies by the government to secure the support of the provider doctors and mission facilities, respectively, in the adoption of the NHS system of Ghana in the 1960s.

#### **4.4.4. Implementation**

The implementation of the NHS benefited immensely from Ghana’s economic prosperity and competent bureaucracy at the time of independence, as well as the government’s strategy of sidelining all potential opponents of the policy. With a per capita income comparable to countries such as South Korea and Singapore, Ghana was the most prosperous country in the Sub-Saharan Africa region at independence (Werlin, 1994; Asare & Wong, 1999; Mazrui, 2006). Much of its prosperity can be attributed to the huge reserves it inherited from its colonial

master, Britain, and the high prices of gold and cocoa, which had been the backbone of the nation's economy (Saleh, 2013, p. 21). For instance, according to Biney (2011), Ghana's reserve was about £200 million sterling at the time of independence. With its GDP growing at about 6% per annum between 1957 and 1960, Ghana was one of the countries with the highest level of growth in the world immediately after gaining independence (Coleman, 2011; Grischow, 2011). Cocoa exports grew exponentially and constituted the largest portion of the country's GDP during the 1950s and 1960s (Mensah, Oppong, Bobi-Barimah, Frempong & Sabi, 2010). In this regard, Ghana became not only prosperous, but also the country with the "highest per capita income in West Africa" (Mensah et al., 2010, p. 10). Confirming the above, Agyepong (2013) emphasized during the interview that, "at independence, Ghana had a budget surplus. Because it was after the Second World War, cocoa prices had been high, there hadn't been so much investment in social infrastructure so Ghana had a budget surplus that is why Kwame Nkrumah was able to do so much". Coleman (2011) indicated similarly that "the favourable economic conditions made Nkrumah to implement his socialist's ideology" (p. 11), including the establishment of the NHS. Akosa (2013) explained that,

From 1951, hospitals had to be built, so you had Kumasi "G" [General] hospital built, you had Afia Nkwanta built, you had Cape Coast municipal hospital built, you had Ho municipal hospital built. All these [hospitals] were built in response to the goal of the government in making sure that every region had a hospital. It then proceeded to the larger districts, so there was the Bekwai [hospital], there were hospitals in other bigger districts. [All those hospitals] were all built to provide infrastructure. In addition to that the Ministry of Health created a system that was to support nutrition, sexual and reproductive health, and public health. The Medical Field Unit was also established, with headquarters in Kintampo, to oversee sanitation and other aspects of health care delivery.

Beyond infrastructural development, outpatient care was made completely free for all residents, including non-Ghanaians, in all public health care facilities in May 1962 (Arhinful, 2003).

The quality and subsequent politicization of Ghana's bureaucracy also enhanced implementation of the NHS. Twumasi (1981) stresses that "the Nkrumah government inherited a good civil service administration, [and] manpower ... [and] decided to increase training for



health workers” (p. 149). Also, as Biney (2011) emphasizes, the government also had the opportunity after independence to Africanise the public service, a situation that eventually resulted in generating “patron-client relationships” in the public service. The “patron-client relationships” led to a significant number of people, mostly party supporters, getting employed in the public sector (pp. 110-111). For example, K. A. Gbedemah, an Nkrumah’s loyalist, was appointed to head the metamorphosed MoH (Coleman, 2011, p. 10). Dr. Eustace Akwei was also entrusted with the administrative functions of the ministry. Those appointments vested the implementation process with the requisite political leadership and expertise and eliminated the possibility that administrators from the previous regime would sabotage the implementation of the NHS system.

Another factor that enhanced the implementation of the NHS was the incremental approach the government adopted. For example, instead of implementing the basic content of the policy all at once, the reformers did so in phases. As suggested above, the expansionist program in relation to medical care infrastructure was the first to be carried out in the 1950s (Twumasi, 1981; Coleman, 2011) before banning private health care and the collection of user fees in medical facilities in 1961, as well as making medical care free for all residents, include foreigners in 1962 (Arhinful, 2003; Coleman, 2011). The incremental approach is believed to have allowed the government enough time to think through the reform efficiently and address grievances satisfactorily (Akosa, 2013).

#### **4.4.5. Sustaining the Policy**

Due to instability in Ghanaian economy and politics after independence, sustaining the NHS system was problematic. Grischow (2011) notes that beginning in the mid-1960s, the Ghanaian economy suffered significant slowdowns. For example, as Agyepong (2013), a former Director of Health in the GHS, noted during the interviews, “we found out that we were not generating

enough taxes, our economy couldn't support it". Also, the performance of the existing State-owned Enterprises (SOEs) reduced drastically (Arhinful, 2003; Mensah et al, 2010). According to Mensah et al (2010), the "poor performance of the SOEs caused further economic deterioration and annual inflation jumped from about 6% during 1965-73 to 50% during the following decade" (p. 11). Biney (2011) notes that the international value of cocoa, which was the country's main export, also declined, creating major financial difficulties for the government after 1960. For example, the price of cocoa, which was anticipated at 400 cedi (Ghana's currency) per ton turned out to be only 356 cedi in 1964, falling even further to 276 cedi in the following year. Biney (2011) reports that, as early as 1963, Ghana's per annum deficit hovered around £50 million pound sterling, which was equivalent to 33% of its total government expenditure. In the midst of this crisis, the average growth rate fell to about 2.8% in part because of an overvalued exchange rate. This, in turn, increased the price of goods produced in the country (Coleman, 2011, p. 11). According to Carbone (2011), the deterioration of Ghana's economy had a corresponding impact on the survival of the NHS system. As he notes, "the country's economic conditions were gradually worsening, as were the functioning and quality of free public health care" (Carbone, 2011, p. 388). As Agyepong (2013)<sup>24</sup> added during the interview, "it wasn't that anybody thought the tax funded system was bad – it was a great idea – but our circumstances did not make that great idea work for us".

The Nkrumah's government introduced foreign exchange and import restrictions to deal with the crisis (Arhinful, 2003). Although these restrictions were expected to generate more revenues, they did not prove fiscally sustainable (Arhinful, 2003). Hence, Nkrumah adopted other techniques to address the crisis and to protect his entire administration; these are also believed to have indirectly helped to sustain the NHS system over time (Coleman, 2011).

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<sup>24</sup> Agyepong is a public health physician, a researcher, and a member of the design team of the Ghana's National Health Insurance Scheme. She was also the Greater Accra Regional Director of Health Services in Ghana.

For instance, Nkrumah tried to eliminate all political opponents in order to concentrate the power of the CPP. He did so by banning all political demonstrations and actions, particularly those organized along ethnic and religious lines. In 1958 he also introduced the Preventive Detention Act, which legitimized arresting and detaining opponents of the CPP without trial (Grischow, 2011). According to Coleman (2011), “in 1965, instead of holding scheduled elections, Nkrumah announced on the radio the names of persons he had chosen to go to the new parliament” (p. 11).

Additionally, the CPP “co-opted and absorbed” labour unions, which had frequently been obstacles to policy change (Grischow, 2011). In order to reduce the influence of the unions, the government introduced the 1958 Industrial Relations Act, which limited the membership of the Trade Union Congress (TUC) to only 24 official unions. The party also absorbed the Farmers’ Council and other organizations, including those involving women and youth. As Grischow (2011) noted, in the end “membership of ... [the above] organizations became simply membership in the CPP [and]... parliament became the sole instrument of the CPP” (p. 183). Finally, in order to end all oppositions to its development programs, including the NHS, the CPP outlawed strike actions (Grischow, 2011).

Furthermore, the CPP co-opted the media, making it a key proponent of the government’s development agenda, including the NHS system. The process began with the 1957 creation of the Ghana News Agency (GNA); the GNA was charged with collecting and disseminating information, as well as promoting the broad programs of the government (Biney, 2011). Aware of high levels of illiteracy in the country, the government made the radio to broadcast in the local dialects so as to enable it to reach more Ghanaians. In 1959, the Ghana Institute of Journalism (GIJ) was also established with a mandate of training journalists who would promote the government’s development agenda. For example at a journalists’ conference in Accra in 1963, Nkrumah reportedly spelled out the role of the African journalist:

“to the true African journalist, his newspaper is a collective organiser, a collective instrument of mobilization and a collective educator—a weapon, first and foremost, to overthrow colonialism and imperialism and to assist total African independence and unity” (Biney, 2011, p. 114). Speaking to the same situation, Biney (2011) also emphasized,

In Nkrumah’s opinion, journalists had to be fully committed to the principles of the CPP. ... the press, radio, and television were not simply arenas of public discourse on national issues ‘but a closely guarded and tightly controlled propaganda machine for achieving the major objective of political education, the promotion of socialist ideals, national unity at home, the projection of Ghana’s image and foreign policy and for the liberation and unification of Africa’. When he inaugurated Ghana’s television service in July 1965, he made it clear that it was to be used as an ideological tool to assist in the socialist transformation of Ghana (p. 114).

As part of the coercive strategies to sustain his policies and government, Nkrumah harassed and even banned media outlets that opposed his administration. All opposition media outlets have been closed down by the time of Nkrumah was overthrown in 1966. For example, the *Ashanti Pioneer*, the main opposition newspaper, was banned in October 1962 (Biney, 2011). Thus, besides usurping the Ghanaian media to promote its policies, which included the NHS system, the government worked relentlessly to stifle all opponents of his regime.

In addition, Nkrumah used the political acumen he possessed to his advantage, including his outstanding gifts of oratory and “charismatic” or “charming” personality (Iijima, 1998; Biney, 2011, p. 108). Apter (1972) notes that one of Nkrumah’s key strengths, which contributed significantly to his political successes, was that he managed to establish himself as a charismatic leader. Two main factors accounted for Nkrumah’s emergence as a charismatic leader. First, having led the people of Ghana to independence, he was naturally expected to provide all that the people had failed to enjoy under colonialism, including quality health care. Second, through the use of religious and traditional symbols and slogans, he managed to effectively project himself and his ideas to maximize public attention. Indeed, the use of those symbols in the political arena ran through the entire fabric of his administration. For example,

the creed of his “Verandah Boys”<sup>25</sup> described the CPP as “the opportune Saviour of Ghana” and Nkrumah as the liberator, among other things (Timothy, 1955, p. 81 quoted in Iijima, 1998, p. 184). Nkrumah could also connect very well with ordinary people, which made him even more popular.

However, as Coleman (2011) notes, “as Nkrumah became more and more dictatorial, opposition to him increased” (p. 11). Not only did that lead to his overthrow in February 1966, but it also made it even more difficult to sustain the NHS system. For example, the opposition party (UGCC) and subsequent governments, mostly those with ideological orientations opposed to socialism<sup>26</sup> and with the aim of reducing public sector costs, attempted to dismantle the NHS system. Nonetheless, they all failed in the face of massive public resistance (Arhinful, 2003). As Apoya and Marriott (2011) note, “the large-scale popular support for free health care deterred any serious attempts to introduce user fees up until the mid-1980s” (p. 17).

In this context, besides the Nkrumah government’s deep commitment to it, and the ideational and repressive strategies it employed, a critical factor in the sustenance of the NHS system was the large-scale constituency the policy was able to generate over time. This suggests that, to sustain a policy change, the commitment and strategies of the reformers may need to be buttressed with the ability of the new policy to establish constituencies outside the reformers to defend it even in their absence.

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<sup>25</sup> The “Verandah Boy’s” concept was coined to represent the rank and files of the United Gold Coast Convention (UGCC), which was the biggest movement during the initial stages of the independence struggle of Ghana. It is believed that the rank and file usually had their lunch on the verandah of the main dining room, while the leaders had theirs in the room whenever the movement had a meeting or campaign trip. After being fired as General Secretary, Nkrumah is believed to have tapped into the rank and file, or “Verandah Boys,” to form the CPP. As part of the underlying principles of the CPP, Nkrumah introduced the “Verandah Boy’s” creed, which was purported to make him supreme, as it read: “I believe in the Convention People’s Party, The opportune Saviour of Ghana and in Kwame Nkrumah its founder and leader, who is endowed with the Ghana Spirit, Born a true Ghanaian for Ghana suffering under victimisations was vilified, threatened with deportation” (Timothy, 1955, p. 81 quoted in Iijima, 1998, p. 184).

<sup>26</sup> They include the National Liberation Council (NLC), which ruled Ghana from 1966 to 1969, and the Progress Party (PP), which took over from the NLC from 1969 to 1972.

#### **4.5. Causal Interactions**

In this section, I will show how various causal factors interacted over time to ensure the transition to the NHS system in the 1960s. Before NHS came on the agenda, for instance, the health system was largely expensive for, and discriminatory against, non-Europeans. In other words, it needed significant overhaul. However, that expectation did not gain significant governmental attention until after the transition to self-government in 1951, with a Ghanaian as prime minister. The 1951 political transition offered an opportunity for the country to look after the welfare of the African population for the first time. The first African prime minister seized this opportunity and created a commission to investigate the state of the domestic health care system and to make recommendations for policy change. Expertise was the main criteria in forming this commission, and since many of the high quality health care experts at the time were foreigners, most of the commission's members were foreigners, particularly British. Among other things, the commission recommended the elimination of user fees, the construction of more health facilities in the country, and vesting ownership of major health care facilities in the state, a recommendation that closely aligned with the recently created NHS system of Britain, Ghana's former colonial masters. While it might have been influenced by that system, the commission's recommendations also appeared to have been shaped by the information it gathered through the domestic enquiry and the economic boom of the 1950s and 1960s, as well as the global trend towards big government.

Although he approved of the recommendations of the commission in principle, Nkrumah only followed through on them after 1957 and, most importantly, after 1960, when Ghana had attained complete constitutional autonomy, or republican status, from the UK. Complete autonomy gave Nkrumah much more power and a wider window of opportunity to pursue path-departing policy change that would serve the interests of native Ghanaians. Also important was the fact that, by 1960, there had also been a significant rise in mortality and

morbidity rates, as well as overcrowding in the health care system, as a result of both population and economic growth (Addae, 1996).

The government appointed Dr. D. Brachott to design a ten-year medical plan for the country. Brachott was then a high level health care bureaucrat and professor of public health in Jerusalem, Israel at the time. The design of that policy was very much akin to the British NHS-system and the recommendations of the Maude Commission of enquiry. In fact, Brachott had come to Ghana as part of a high-powered medical and technical assistant delegation from Israel. His expertise in health service development was a compelling reason for his appointment. In designing Ghana's NHS system, Brachott, like the Maude Commission members before him, travelled across the country to solicit ideas about pressing health issues that needed to be addressed. However, the policy's affinity with the British NHS system and the Maude Commission's report demonstrates the extent to which Brachott's ideas were also shaped by existing policy legacies, as Ghanaian actors drew lessons from policies implemented elsewhere around the world, including the UK, where the NHS model had emerged in 1948.

The new policy was then sent for adoption. This process was shaped by the state's institutional configuration, the role of vested interests and the strategies of the reformers. While the state's concentrated institutional configuration facilitated the adoption process, vested interests within the existing, privately-operated system were strongly opposed to the NHS. Medical officers and facilities in particular opposed the policy because they thought that the change would result in a loss of autonomy and their ability to generate income through user fees. In order to neutralize opposition, the government compensated the medical officers with annual allowances and the mission hospitals with grants-in-aid.

The implementation phase was, however, supported by the economic boom in the country at the time, high levels of governmental commitment to the policy and the strategies

of the reformers. The economic boom made enough money available for the country, while the government's commitment to the policy helped in ensuring that those monies were utilized to support policy's implementation over time. However, to win time to deal with opponents and hopefully secure their support, the government implemented the policy change in phases and gradually.

Sustaining the policy change also involved a number of factors, including the political commitment and strategies of the government and the new stakeholders the policy developed in that time. For instance, regarding the key role of political commitment, the government basically ignored all criticisms and recommendations meant to dismantle the policy in the face of the crisis. In particular, instead of addressing the revenue problem by introducing cuts in the health care sector, the government introduced economic measures such as import licenses and tariffs and left the NHS system intact. In the face of increasing opposition to its rule, the Nkrumah government resorted to repressive strategies involving media censorship and the banning of political parties and other oppositional groupings. While they protected the NHS from collapse, those strategies fed underground opposition and armed mobilization, which led to the overthrow of the regime in 1966. The policy, however, continued after Nkrumah's overthrow. This was due in large part to the new stakeholders' opposition to change, coupled with the fact that some of the regimes that came after Nkrumah subscribed to ideological orientations that aligned with the existing NHS system.

#### **4.6. Theoretical Implication of the Change to an NHS-type System**

The above discussion is consistent with the theory of dynamic or actor-centred institutionalism, particularly as posited by the theoretical framework underlying this study. As indicated, this theoretical framework combines Kingdon's (2003) "window of opportunity" approach and Grindle's (2004) "dynamic political process" framework, among others. In particular, it shows



how policy change is mediated by interactions among politico-economic factors and actors across five policy stages - problem definition and agenda setting, formulation, adoption, implementation and sustainability. While they appear independent of each other, in reality these stages operate interdependently. That is, developments at one stage of the policy process tend to shape developments at subsequent stages. For example, the compensation offered to medical doctors at the adoption stage locked-in policymakers; they had to continue to pay doctors even when the economy had deteriorated. Similarly, the use of repression at the implementation stage contributed to the overthrow of Nkrumah and the challenges of continuing the NHS system afterwards.

The study also revealed dyads of actors and how they tended to shape the process of policy change differently. These actors include domestic, international, proponents and opponents. The domestic actors include the government of Ghana, the medical doctors and the mission hospitals in Ghana at the time. Also, both the Maude Commission of enquiry and the Dr. Brachott design team were constituted by the government of Ghana. Their members, however, were largely foreigners. Their knowledge of the British NHS partly shaped policy in Ghana. Members of the Maude Commission, Dr. Brachott, and the government were key proponents of the policy, while the medical doctors and facilities were its key opponents. While both sets of actors attained some successes, the proponents appeared to have made the most success in shaping the direction of the change. For example, although medical doctors and mission facilities both managed to secure some compensation and shaped the implementation process significantly, they were not successful in their overall quest to overturn the NHS system. Also, different proponents had a larger impact on shaping the policy change at different stages of the process. For example, while they were influential in shaping the agenda and content of the policy, respectively, the Maude Commission and Dr. Brachott did not strongly impact the implementation process, which was shaped by service providers and special

appointees of the government in power. In fact, as British and Israeli citizens, most of the above actors returned to their countries soon after the policy was adopted. Dr. Brachott, for example, stayed in Ghana for just two years (Addae, 1996). The adoption stage was also shaped by Nkrumah's ability to capitalise on the principle of party discipline in the legislative assembly. As indicated, sustaining the change was also shaped by commitment and strategies of the government and the vested interests the policy built overtime.

Combining ideas from both Kingdon (2003) and Grindle (2004), the author observes that contextual factors created a window of opportunity for policy change and also shaped the strategic choices of the reformers. In relation to Kingdon's (2003) framework, the study showed how the process of transitioning to political independence; the election of Nkrumah as both a socialist and a nationalist leader; and the discriminatory, expensive and poor nature of the Ghana's health system at the time; the economic boom of the 1960s; and the global shift towards big-government, including the NHS system, converged to create a window of opportunity for change. The opportunity was then seized by the government, which, as Grindle's (2004) framework suggests, demonstrated a high commitment to the policy and put together teams of experts to study the health care situation and make recommendations for action. The design of the policy and subsequent stages of the policy process, as indicated above, were also shaped by reformers' politics and ideology, research and evidence, existing policy legacies, the diffusion of ideas from the British NHS system and political strategies, which enabled the reformers to stave off opponents of policy change. These remarks are consistent with the analytical framework of this study, especially, the emphasis on reformers or policy entrepreneurs and their strategies.

This study, therefore, contributes to both the window of opportunity approach (Kingdon, 2003) and the policy as political process model (Grindle, 2004) by showing how their combined insights can enrich our understanding of policy change. For instance, while

Kingdon's (2003) concept of windows of opportunity enables us to understand the factors that drive change, on its own, it falls short of explaining how the window of opportunity was seized by reformers, beyond the agenda setting stage. By emphasizing the role of political commitment, design teams and reformers' strategic choices in driving the change across the entire policy process, from agenda setting to sustainability, Grindle's (2004) dynamic political process framework provides additional insight on how policy change occurs. Yet, on its own, this framework does not account for how certain contextual factors may trigger policy change in the first place, something the work of Kingdon (2003) points us to. A combination of these two approaches, therefore, provides a richer framework for understanding the transition to NHS in Ghana. In addition, the topic confirms the relevance of elements of the integrated framework derived from various institutional perspectives, particularly the role of material factors such as compensations, tactics such as incremental implementation and ideational strategies such as framing processes. It also reveals additional strategies policy entrepreneurs in Ghana employed, namely the use of repression, such as ban of political parties, co-optation of labour, media censorship and controls, these are largely ignored in the existing literature on health policy change.

#### **4.7. Conclusion**

This chapter focused on the development of the NHS in Ghana and why and how it was achieved despite the marked opposition from vested interests, such as medical care providers. The analysis, as summarized in Table 2, below, shows that a combination of factors led to the radical health care change in post-independence Ghana.

**Table 2. Summary of factors leading to the introduction of the NHS system**

<b>Factors</b>	<b>Specifics</b>	<b>Contributions</b>
<b>Conjunctures</b>	<ul style="list-style-type: none"> <li>• Discriminatory and expensive health system;</li> <li>• Attainment of self-government;</li> <li>• Booming economy;</li> <li>• Global trend towards big-government</li> </ul>	<ul style="list-style-type: none"> <li>• They created windows of opportunity for change rather than determined the specific policy change to pursue.</li> </ul>
<b>Policy entrepreneurship</b>	<ul style="list-style-type: none"> <li>• The Nkrumah government</li> <li>• The Maude Commission</li> <li>• The Brachott design team</li> <li>• Cabinet and parliamentarians</li> <li>• Ghana's quality bureaucracy</li> <li>• The vested interests or new stakeholders the policy developed over time</li> </ul>	<ul style="list-style-type: none"> <li>• They seized the open windows to propose the NHS system onto the agenda.</li> <li>• They subsequently saw policy change through the remaining stages of the policy process (design, adoption, implementation and sustainability).</li> <li>• Different policy entrepreneurs playing different entrepreneurial roles were identified across various stages of the policy process.</li> <li>• Their leadership, strategies and commitment to change made them unique and relevant for the changes.</li> </ul>
<b>Institutions</b>	<ul style="list-style-type: none"> <li>• A party-disciplined democratic parliament with government holding majority of the seats</li> <li>• After 1964, the regime transitioned to a one-party state</li> </ul>	<ul style="list-style-type: none"> <li>• These concentrated institutions minimized veto points for interests to overturn the policies.</li> <li>• They also eased the ability of the policy entrepreneurs to adopt the new policies.</li> </ul>

These factors involved the role of windows of opportunity created by the transition to self-government in the 1950s and early 1960s, the lack of accessibility to health care due to discrimination and financial barriers, the election of a socialist and nationalist leader at the time of independence, the booming economy and the global trend towards broad welfare state regimes at the time. The above windows of opportunity were seized by the government, which set up a team of experts (the Maude Commission) to study the health care situation in Ghana in order to make recommendations for policy change. After the recommendation, Dr. Brachott was charged to design the policy, which was subsequently adopted, implemented and sustained up to the 1980s. While contextual factors shaped the change, the policy entrepreneurship or the leadership, commitment and strategies of the above actors in seizing the existing opportunities and countering subsequent challenges were the most critical factors. For example, using different political tactics, including the incremental approach to policy implementation,

framing and compensation, policy entrepreneurs managed to shift Ghana's health care system from the regime of a colonially-centred user fee model to a universal NHS-state model, despite the resistance posed by health care providers and the economic challenges it faced after 1964. These findings suggest the need for scholars to pay attention to how the ingenuity of reformers may work in tandem with other factors to surmount forces of path-dependency and institute and sustain path-departing policy change.

## CHAPTER FIVE

### THE ESTABLISHMENT OF A USER FEE SYSTEM

#### 5.1. Introduction

In the early 1980s, Ghana moved significantly beyond its NHS system by introducing a cost recovery or a user fee model that required health care users to make out-of-pocket payments before services would be delivered to them. The main goal of the new policy was to generate additional revenue, which would account for only 15% of the total operating costs of public health care. However, as I will explain in the next section, the policy change led to in a remarkable transition in the mode of financing, delivery and access to health care in the country. This chapter examines the process of establishing the user fee model with the goal of understanding why and how the policy change occurred within the timeframe in which it did, despite certain countervailing factors. For example, whereas some modes of cost-sharing had been enacted in Ghana in the past, almost all of them had failed to reach the level of implementation, making user fees one of the most critical paths to policy change in the history of the country (Arhinful, 2003; Coleman, 2011).

Having initially portrayed itself as leftist and populist and as embracing a neo-Marxist brand of socialism (Hutchful, 2002), most people expected the government at the time (PNDC) to maintain the status quo, rather than embrace a far-reaching policy like user fees. This is the case for a few reasons. First, as a leftist regime, the PNDC was expected to first and foremost protect the vulnerable and the working class by improving the existing NHS system, rather than committing to user fees that might impose financial burdens or even hardships on these constituencies. Such an expectation seemed legitimate given that the Ghanaian economy had deteriorated such that the entire public could feel its negative effects. As Baidoo (2009) indicates, “the economic crisis led to most Ghanaians becoming skeletons overnight and...eating whatever they lay their hands on – mostly poisonous roots and leaves” (p. 43).

Second, by introducing user fees, the PNDC also stood the risk of being deposed, as almost all the governments that had attempted such a change had faced a similar fate. In fact, this should be expected in the case of the PNDC, given its political reliance on the working class, who, in addition to being potentially affected by the policy, had consistently shown their aggression towards user fees in the past (Hutchful, 2002). Beyond the working class, user fees had a tendency to inflame protests from the general public and the armed forces, whose historical aversion towards user fees were also evident (Arhinful, 2003). Despite these factors, the user fee policy was not only implemented, but also sustained for a number of years. In fact, existing accounts show that, by the time the government left office in 2000, the fees had risen dramatically, sometimes by over 5000% (Coleman, 1997; Nyongator & Kudzin, 1999).

Drawing on both the document reviews and the in-depth, semi-structured interviews, this chapter explains how the economic crisis of the 1980s, combined with other factors, including the strategies and commitment of key reformers, ensured the transition to user fees. In this context, this chapter confirms the theory of actor-centred institutionalism, showing its applicability to the issue of health care change in Ghana in the 1980s. Contributing to this theory, this chapter also suggests that additional mechanisms – frames, legislative inaction and coercion – help explain path-departing policy change.

## **5.2 Examining the Magnitude of the Change**

Before proceeding to a detailed analysis of the transition to the user fee policy, it is crucial to examine the nature and magnitude of this change so as to properly conceptualize it. Like that of the NHS system, the magnitude of the shift to user fees is explored in reference to spending and institutional factors.

### 5.2.1. Spending Change

Contrary to the general expectation that it would fall, public expenditures on health care eventually rose after the introduction of user fees (Hutchful, 2002), increasing from 6.5% of total government expenditure in 1980 to 8.7% in 1985, after a short-lived fall to 4.4% in 1983 (Demery, Chao, Bernier & Mehra, 1995). By 1987, public spending on health had ballooned to about 12% of total government budget, although it fell to 8.7% in 1994 (Demery et al., 1995). The trend in public health care expenditure in relation to the GDP reveals similar results; it shifted from 0.9% in 1980 to 0.38% in 1983 and to 1.07% in 1985 (Demery et al., 1995).

However, as seen in Table 3, below, much of the increase in public health care expenditure can only be seen in nominal rather than in real terms, when real public spending for the period after the user fee policy was introduced is compared to the period preceding the policy change. In the period just before the policy change, the economic crisis had worsened deeply, resulting in the government's inability to invest in the health sector as needed.

**Table 3 Nominal and real government health expenditures of Ghana 1978 - 1988**

Year	MoH(a) Health Expenditures (Nominal) (Millions ø)	CPI(b) Accra (1980=100)	MoH Health Expenditures (Real) (Millions ø)	Population estimate (Thousands)	Real per capita Expenditure
	(1)	(2)	(3) [(1)/(2)]×100	(4)	(5) [(3)/(4)]
1978	289.8	43.2	670.8	10,550.0	63.6
1979	278.2	66.6	417.7	10,820.0	38.6
1980	429.9	100.0	429.9	11,100.0	38.7
1981	510.4	216.5	231.6	11,390.0	20.3
1982	485.7	264.8	183.4	11,690.0	15.7
1983	586.6	590.1	99.4	11,990.0	8.3
1984	2,112.3	824.1	256.3	12,206.0	21.0
1985	2,612.0	909.1	290.6	12,620.0	23.0
1986	6,496.0	1272.7	510.8	13,100.0	39.0
1987	6,951.9	1718.2	404.6	13,500.0	30.0
1988	9,832.6	2319.6	423.9	13,851.0	30.6

Source: Waddington and Enyimayew (1989, p. 42)

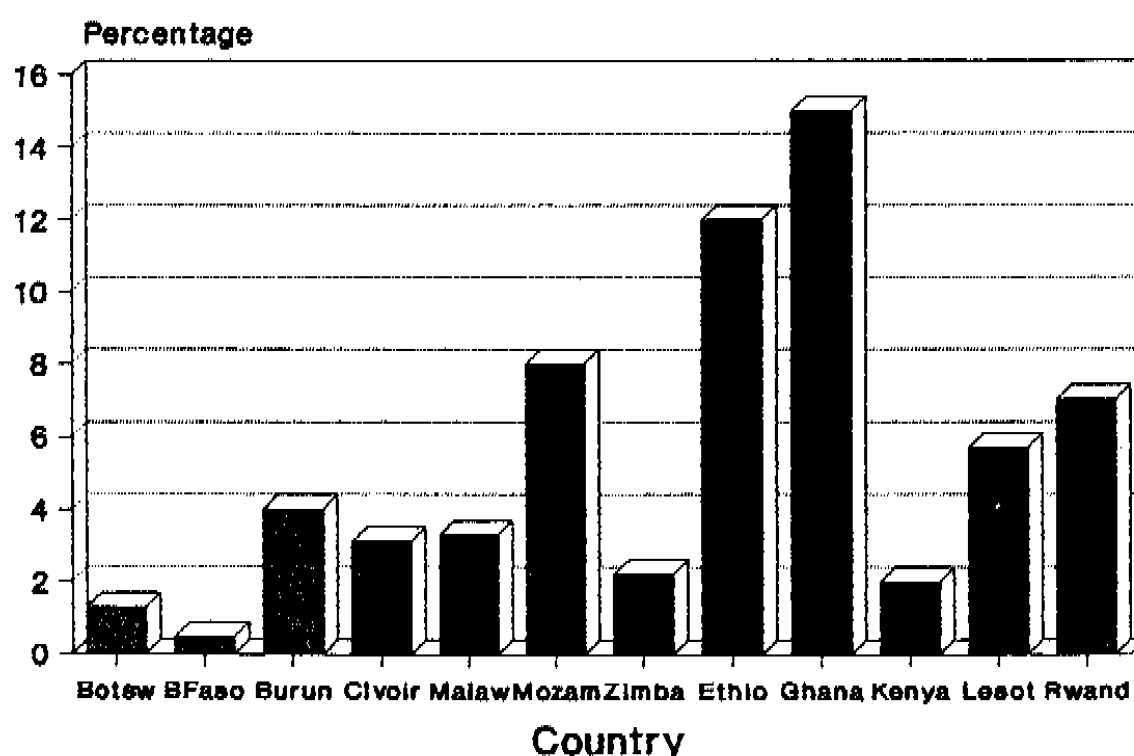
However, real public spending for the period after the user fee policy was introduced was still lower than that of the period from the 1960s to 1980s, when the NHS system was in operation



(see Waddington & Enyimayew, 1989, p. 42). For example, as Coleman (2011) notes, “the Ministry of Health expenditures in 1984 amounted to only 45.4% of what they had been in 1978” (p. 14). The majority of the increased expenditure had also gone to pay for the salaries of health care personnel rather than expanding access to health care (Nyonator & Kutzin, 1999; Hutchful, 2002). For example, in their study involving 24 facilities in the Volta Region, Nyonator & Kutzin, (1999) found that between 67% and 88% of public spending focused on staff salaries.

The rise in public expenditure on health care also occurred at the same time as the growth of private health care expenditure. As Demery et al. (1995) note, private spending on health care accounted for 51% of the total health expenditure in 1995. The African Development Indicators (2001) reported a similar trend between 1990 and 1997, with private health expenditure relative to GDP still higher than public health expenditure as a portion of GDP (1.6% compared to 1.4%). The World Health Organization (WHO) noted that private health care expenditure had surpassed public expenditure significantly, reaching about 60% of total expenditure on health care in 2002 (WHO, 2004). The implication of the above is that under the regime of user fees, and for the first time in post-independent Ghana, private expenditure on medical care outpaced public expenditure. User fees “accounted for about two-thirds of health centre non-salary revenues and more than 80% of hospital non-salary revenues in public sector facilities in the Volta Region” (Nyonator<sup>1</sup> & Kutzin, 1999, p. 335). As illustrated by Figure 2, Ghana’s total user fees revenue was the highest across SSA, with an average of just 5% of the operating costs of health care (Creese, 1991).

**Figure 2. Sub-Saharan Africa: Revenue from fees as % of ministry of health budget**



Source: Vogel (1989) cited in Creese, (1991, p. 6)

User fees also formed an important portion of the income of medical care users. Describing the impact of the policy change on service users, Lavy and Quigley (1993), for instance, note, “these are very poor households. On average one consultation costs 877 cedis or only about US\$3.00. But per capita income is only 71, 000 cedis a year. Therefore, one medical consultation in a four-week period consumes roughly 15% of monthly income” (p. 10, cited in Hutchful, 2002, p. 131). Consumers of the user fee system also bore the full costs of the drugs, which represent one of the largest shares of the total health care costs in Ghana (Arhinful, 2003; Coleman, 2011). As well, it was the largest share of total private health expenditure (Ramanchandra & Hsiao, 2007).

Much of the increased public expenditure on health care also increased regional inequities in health service provision. For example, whereas per capita health expenditure for Greater Accra, the country’s most urban and developed region, was 2,442 cedis (Ghanaian currency) in 1992, it amounted to 1,546 cedis and 1,289 cedis in Central and Volta, which are

among Ghana's poorest and most rural regions, respectively (Demery et al., 1995). Hutchful (2002) witnessed a similar situation between 1989 and 1992. He notes, "in 1989 urban dwellers with one-third of the population received 42% of health spending. In 1992, this rose to 48.7%, while the proportion of rural areas fell from 58% to 51.3%" (p. 130). Also, whereas per capita subsidies for urban dwellers rose from 2,223 cedis to 5,808 cedis (Ghana currency), rural dwellers' subsidies increased from 1,459 cedis to only 3,039 cedis (World Bank, 1995, p. 39 cited in Hutchful, 2002, p. 130). Part of the reason for the inequity may be the government's overriding focus on reducing costs rather than building more health care facilities to cover people in more rural and poorer regions of the country. It could also be because a disproportionate share of health care facilities was located in the better off urban areas and in the South rather than in the North and in rural areas that needed those facilities the most (Hutchful, 2002). Thus, although government support for the health sector increased, a greater proportion of that was allocated to the better off at the expense of the poor (Adjei, 2013).

### **5.2.2. Institutional Change**

Beyond changes in public expenditure, user fees created structural and qualitative changes with respect to rights and responsibilities under the Ghanaian health care system. In particular, as indicated in Table 1, user fees shifted the provision of health care from the basis of universalism to targeting, whereby only a small fraction of the population, particularly paupers, children, the aged, and health staff, could legally obtain free services.

Referred to as "the most comprehensive cost recovery legislation in West Africa" (Arhinful, 2003, p. 87), Ghana's user fee legislation also caused a shift from the provision of comprehensive benefit coverage offered under the previous NHS regime to a minimum benefit package for targeted populations only. With this change only consultations for certain communicable diseases, such as tuberculosis and leprosy, and immunizations were exempted

from fee payment, leaving all other services subject to user fees, including medications, inpatient care, outpatient care, laboratory tests, accommodation and meals in hospital (see Table 1).

The change seems even more radical when one considers the fact that the few exemptions under the user fee policy were never effectively implemented (Ofori-Birikorang, 2009). In fact, the majority of the people, including those potentially exempted from user fees, were not even aware of the existence of the fee exemption schemes. For example, based on his interview with key stakeholders, Maclean (2002) observed that only 4.5% of them knew about the legislated fee exemptions. This implies that normally, in practice, not only was free health care non-existent, but also the people who should have been legally exempted nonetheless paid the user fees, or avoided care because of the user fees (Adjei, 2013).

Before the introduction of user fees, health service was delivered mainly by facilities that were owned and managed by two main actors - the public sector, represented by the MoH at the time, and the non-profit private sector, which included mission or religious-based facilities. With the creation of the user fee model, new sets of actors emerged. Within the public sector, for instance, the Ghana Health Service (GHS) was created in 1997 to take away the responsibility of service delivery from the MoH, which was left with the obligation of policymaking. In addition to the non-profit private actors, there was also an aggressive emergence of several for-profit private actors, comprising mainly of self-financed providers, including hospitals, maternity homes, clinics, pharmacies, chemical sellers, and laboratories after the introduction of the user fee policy (Makinen, Sealey, Bitrán, Adjei & Muñoz, 2011). For example, by the 1990s, there were about 41 hospitals and 64 clinics in Ghana that belonged to about 45 not-for-profit private institutions<sup>27</sup>, as well as 12 hospitals, 402 registered clinics,

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<sup>27</sup> Most of these non-profit delivery agents were the same as the Religious-Based Providers (RBP) that existed during the NHS regime.

362 registered pharmacies and 3,077 licenced drugstores that were owned by for-profit private organizations (Demery et al., 1995). As reported by the 2000 Ghana Living Standard Survey, taken together, the private-for-profit and the private-non-profit actors accounted for about 52% of the total market of health care in Ghana (Makinen, Sealey, Bitrán, Adjei & Muñoz, 2011). The implication of the above is that the user fee policy transformed the face of the health sector from one that was nearly monopolized by the government under the NHS-type system to one that was dominated by the private sector. That said, the public sector continued to command a significant share of all hospitals and hospital beds (63% and 70%, respectively), even after the introduction of user fees (Asenso-Okyere, 1995).

Furthermore, access to health care declined. For instance, outpatient attendance reduced from 10-11 million people in 1973 to about 5 million in 1987, representing about 38% of the population at the time (Lavy & Germmain, 1995). In some hospitals in Ghana, utilization rates declined 32.4% (Waddington & Enyimayew, 1989, 1990; Criel, 1998). The greatest impact user fees had was on poor and rural Ghanaians who could not afford the fees (Asenso-Okyere, 1995; Senah, 2001; Ofori-Birikornag, 2009). For instance, barely 20% of the poor sought health care relative to about 51% of people in the top quintile in 1989 (Demery et al., 1995). These observations indicate clear cases of commodification under the user fee regime, which supports the argument that the transition to user fees under the PNDC was a significant change in health policy in Ghana.

Despite these significant changes in health care, there were some points of continuity. For example, the government continued to bear the full cost of the salaries and wages of MoH staff and, significantly, of those of mission hospitals, although their incomes were also supplemented by the fact that many of the exemptions offered under the scheme went to them rather than the poor (Arhinful, 2003). Also, although some repair work done in the facilities was paid by user fees collected, as Hutchful (2002) notes, “the services infrastructure

...training expenses and health education and promotional programmes” were largely paid for by the government (p. 56). Like its predecessor, the user fee system was also curative- and urban-biased, as little attention was paid to promoting preventive and primary health care (Waddington & Enyimayew, 1989, 1990; Kraus, 1991; Criel, 1998; Hutchful, 2002). In spite of these points of continuity, the changes seen after the implementation of user fees were significant.

### **5.3. Why and How the User Fee Policy Occurred**

Analysis of the data shows that a number of factors combined to ensure the shift from NHS to user fees in the 1980s. I back this claim by tracing the development of user fees from problem definition and agenda setting through formulation, adoption, implementation and sustainability.

#### **5.3.1. Problem Definition and Agenda-setting**

Not long after the implementation of the NHS system, it became apparent that it could not be sustained (Adjei, 2013). For instance, government revenue for the health sector diminished dramatically (Arhinful, 2003). In response, as indicated in the preceding chapter, the Nkrumah government introduced import and foreign exchange restrictions, but as Arhinful (2003) notes, these aggravated the situation, leading to shortages of the “capital intensive equipment, essential drugs and supplies” health professionals and facilities needed (p. 50). The intensity of the situation led some actors to question the validity of the NHS system. The GMA was the first to register its disapproval of the existing health system (Adibo, 2013), followed later by bureaucrats in the MoH who basically “questioned the rationality of the approach of extending health services to the majority of the people through construction of health facilities” (Coleman, 2011, p. 13).

Despite these complaints, it was not until the late 1960s when the NLC rightist government created a committee, led by Dr. Easmon, to investigate the problem of health care reform that the idea of introducing user fees to address the financial shortfall in the health sector was first recommended. As Arhinful (2003) indicates, “because of the...recommendations [of the Easmon committee], a statutory dispensing fee (30 new pesewas) was introduced in February 1968, but the directive was withdrawn following public outcry” (p. 50). Another committee, known as the Konotey-Ahulu committee, was set up in 1970 to examine user fees in the country. After travelling to almost every corner of Ghana and digging deep into the archives, that committee recommended the introduction of hospital fees, thereby becoming the second to contribute to the user fee agenda. Arhinful (2003) notes that “on the basis of ... [the Konotey-Ahulu committee’s] recommendations, the government introduced the Hospital Fee Act of 1971 in government health facilities with the aim of reducing excessive demand and contributing to recovering part of the costs of curative services” (p. 51). Coleman (2011) emphasizes, however, that “though the user fee policy was given legitimacy through legislation, it was not implemented because the proponents of the policy were [soon put] out of power” (p. 12). Consequently, as Adibo (2013) noted, “under Limann [’s administration in 1981] ...an LI [for user fees]... was passed, lying [in parliament] for the 21 days<sup>28</sup> [to elapse] when [the] Limann administration was overthrown [by the PNDC on December 31, 1981]” (Adibo, 2013).

When the PNDC came to power in 1981, the GMA, together with the Pharmaceutical Society of Ghana (PSoG), again proposed the introduction of user fees (Adibo, 2013; Adjei, 2013; Agyepong, 2013). Adibo (2013), a key member of the user fee reform team, explains the circumstances leading to the introduction of the user fee policy.

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<sup>28</sup> The parliamentary standing order of Ghana during the Limann administration (1979-1981) required laws passed by parliament to take effect only after 21 days of enactment

The economy was in distress: when we wanted money to import our essential commodities, drugs, and things like that, the Bank of Ghana or Ministry of Finance could not give money to the Bank of Ghana to establish the letters of trading. So there were shortages in the system. So I thought that if we sold drugs, charged other fees, kept the revenue that we generated, and put it in the Bank of Ghana, anytime we wanted to import things we could fall on the bank and take the money to establish the letters of trading. That was the basis of what came to be known as cash and carry [or user fees].

In this respect, the economic crisis crippled the country's ability to even raise adequate revenue to import necessary materials for the health sector. According to Nortey (2013), the economic crisis combined with a rise in population growth, making it difficult for the government to sustain the economy. Consequently, the economic problems ended up affecting the other areas of the Ghanaian society, with the health sector being a critical part of those affected. Adams (2013), who was a key member at the policy design process, notes that the Ministry of Finance's allocation to the MoH in the national budget dwindled. Other areas that were seriously affected as a result of the crisis involved the availability of equipment and drugs in health care facilities. As Akosa (2013) recounted during the interview process,

It was felt that all the period before the user fees, the hospitals didn't have equipment, the hospitals did not have drugs. So when you [people] went to hospital, sometimes prescriptions were written for you [them] to go and buy in private pharmacies. And, of course, let one also realize that the economy wasn't doing well and therefore money for health was very limited and the hospitals, frankly, did not have anything [resources] so it was thought that user fees was going to give the hospital money for them to acquire things [the needed health care resource].

Akor<sup>29</sup> (2013) also confirmed the impact of the crisis on the health system.

All the hospitals were facing shortage of medicine in the pharmacy. They can only buy a small package and then when they bring it, sometimes, the quantities get missing because even health workers were pilfering the drugs; some were taking it for their own relations and so forth. Within a short time, it is gone, everything is finished, so how do we tackle that? Then it meant patients should pay for the drugs so that we can set up a drug recovery fund to be able to replenish the stock. That is how come the need for a user fee policy came to the table.

The above argument suggests that, in the face of the shortages of drugs and other consumables in medical facilities, some health care staff sought to protect the few available medical supplies

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<sup>29</sup> Akor was a public health physician during the 1980s and a key implementer of the user fee model.



for delivery to their relatives after work. But that trend worsened health care quality and equity, as Akor (2013) explained in the same interview,

Quality was impoverished from the patient or client perspective. For example, I expect to get drugs or medicines prescribed and bought from the premises, but there was no medicine. I had to go and buy them from a private source outside the hospital. It was not the thing that most clients were happy with. So out of that situation, government saw the need to do something. And for practitioners, you want medicine for your clients, especially, those in the ward and since it is not available, you have to run out to go and find it... It is not an incentive for you to even practice; it is frustrating that you want to do something for your client or patient and you can't do it at the time when you need it.

Notey (2013) of the Ghana Registered Nurses and Midwifery association also confirmed the impact of the health care situation on the morale of medical staff.

The drugs are not there, equipment are not there to work with and the patients are coming. When I need a thermometer to measure your temperature before I give you medicine, the thermometer is not there and I cannot not go and buy thermometer and put it there. It affects my work, I know what to do, but the things are not there so it affects my work and I cannot give care to the patients, the patients cannot also die or have complications so it affects our work.

The above experiences, among others, informed policymakers about the apparent need to introduce user fees. Given the nature of the situation, as described above, it was predictable that the GMA and PSoG would be the first to complain and call for the introduction of user fees. But in addition to them, as Adibo (2013) noted during the interview, in 1982, when the health care problem had worsened, the MoH was also compelled to develop a user fee proposal for the PNDC government. However, the government rejected the proposal, arguing that it was politically inappropriate to introduce user fees at the time (Adibo, 2013). As a socialist regime, the PNDC's government rejection of the introduction of user fees should not be surprising. Also, as indicated, the preceding government was in the process of introducing user fees when it was ousted by the PNDC. Hence, turning back to introduce a similar policy was seen as potentially troublesome for the regime's reputation and survival. The public might be disappointed, especially as the coup was popularized as a vehicle to end the hardships of the Ghanaian society.

Having rejected the MoH's user fee proposal, the government began to explore a socialist-based alternative to health care financing (Hutchful, 2002). In 1982, for instance, it sent emissaries to the Eastern bloc for financial support. Nevertheless, the Eastern bloc agenda not only failed, but the representatives of the PNDC were advised to negotiate with the IMF and the World Bank for assistance. While it appeared simple, the advice was a bitter pill for the PNDC, given its leftist orientation and support-base (Adjei, 2013). Coleman, (2011) notes that the government "expressed an unequivocal commitment ...to primary health care", which was to be financed through the imposition of tax instead of user fees (p. 13). Its main purpose was to extend health care coverage to at least 80% of the people in rural areas and urban shanty towns by 1990 (Coleman, 2011). Although user fees were then higher on the policy agenda, the PNDC bypassed them and ordered a revision of the primary health care policy, referring to it as "a revolutionary way of looking at the whole health system with a view of ensuring social justice to all citizens" (Coleman, 2011, p. 13). The failure of Ghana's primary health care policy deepened the urgency for reforms but still, instead of user fees, the government decided to impose surcharges on medical imports such as drugs and equipment (Arhinful, 2003). Nevertheless, that policy was also unsuccessful, resulting in "the inability to purchase necessary medical supplies and medications, as well as a decay of health care infrastructures and the cancellation of the existing programs on immunization" (Arhinful, 2003, p. 52).

At the height of the crisis, as Arhinful (2003) notes, "patients did not only have to 'scavenge' their drugs from private sources, but they, in addition, had to carry their bedding, food requirements and sometimes even stationery with them when attending some public facilities" (p. 52). These conditions created a disincentive for patients to purchase care in public medical facilities. Consequently, usage of public medical facilities declined immensely (by about 40%) in the period between 1981 and 1983, when the government finally agreed, although grudgingly, to the policy change (Adibo, 2013).

The interesting thing with this decision was that it coincided with a number of factors. As Adibo (2013) noted, “after the drought and bush fires<sup>30</sup>, the returning of the one million Ghanaians [expelled from Nigeria], the economic crunch on Ghana was too strong so when we raised [health policy change] again they [members of the PNDC government] saw the point”. This implies that, apart from the failure of earlier socialist measures, the gravity of the economic crisis after the 1983 drought and the expulsion of Ghanaian emigrants from Nigeria contributed significantly to pushing the PNDC government to agree to the user fee policy. However, that decision also coincided with the period during which the government adopted the World Bank and the IMF’s Structural Adjustment and Economic Recovery Program (SAERP), which mainly required the country to pursue fiscal discipline by increasing revenue and reducing spending. This was confirmed by Agyepong (2013) during the interview; as she noted, “the World Bank put all these conditionalities that is how these user fees came”. Explaining the conditionalities, Agyepong (2013) added, “it wasn’t only Ghana it was all over Africa and I think it’s a good example of ‘he who pays the piper calls the tune’ - the countries were desperate, they were on their knees so you know if the World Bank says you have to do this before I give you money, they really have no choice so that’s how the user fees came, so again it was a response to drastic changes in the environment”. However, this cannot be interpreted as an imposition in the strict sense of the word. As Akor (2013) noted, “it wasn’t like an imposition, but it was happening around the time when we had started the economic recovery program. The environment was ripened for the introduction of this [user fees] already”. Agyepong (2013) seems to agree with this argument, at least to some extent. He said,

Everybody talks about the World Bank but the truth is that providers were actually pushing for user fees...We had major problems. There were shortages of everything, nothing was available, and so providers had been pushing that if government cannot pay for these services, allow us to charge people something because we cannot do our work. So it was structural adjustment, but like I said things were bad. And even what

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<sup>30</sup> In the early 1980s, a series of bush fires and severe drought occurred in Ghana, resulting in a dramatic reduction in the production of major food and exportable commodities in 1983. In addition to food crops, the bush fires also destroyed most of the cocoa, Ghana’s major foreign exchange earner (Anyemedu. 1993).

was theoretically free was not free in practice. And there were under the table charges and people were given prescriptions, and asked to go and buy gloves, to go and buy cotton wool.

The above passages suggest that the domestic context was perfect for the introduction of user fees even before the World Bank and the IMF came onto the scene. In fact, as indicated, some patients were already paying “under the table” to be able to receive drugs and services in public medical facilities. According to Seddoh (2013), the intensity of the situation created the impression that, most likely, introducing user fees would even be to the benefit of the poor. As he argues,

It was popular because the drugs were not there, there was nothing in the facilities, any time people went to the health facilities, they were given prescriptions and the economic cost of travelling twice for the poor person is big, you go to the hospital and they put a piece of paper [prescriptions] in your hands, you struggled hard to come to the facility only to be told you have to go another 5km to go and find another drug store and you go there and the drugs are even not there and the person dies. It was very high and had to do something about it.

Thus, beyond revenue generation, the user fees were also deemed necessary to promote equity, quality and accessibility in health care.

Explaining how the user fee policy moved onto the agenda, therefore, requires recognizing (a) the number of factors that interacted to create a window of opportunity for the change, and (b) how the open window was seized by key policy entrepreneurs to push the proposed policy change onto the governmental agenda. The window of opportunity was created by the economic crisis of the 1970s and 1980s, which adversely affected health service delivery in the country; the failure of socialist policy approaches to tackle the crisis; the return of Ghanaians emigrants from Nigeria in the early 1980s, which worsened the already precarious economic situation; and a domestic and international environment favourable to change, as characterized by the support and diffusion of the idea of user fees by the GMA, the PSoG, MoH and the IMF and the World Bank in the 1980s. Leaders of the above organizations seized the window of opportunity by pushing user fees onto the PNDC’s agenda. While all of these actors contributed in placing user fees on the agenda, the IMF and the World Bank appeared to

have had the most impact, as they backed their proposal with financial aid that would benefit the entire economy (Hutchful, 2002). The policy was first announced as part of the April 1983 budget (Hutchful, 2002). The policy's announcement in the national budget suggested that the government has finally agreed to introduce the user fee policy.

### **5.3.2. Formulation/Design**

Dr. Moses Adibo, the head of the Policy, Planning and Monitoring Unit of the MoH, led the design of the user fee policy with the involvement of other bureaucrats in the ministry. This was because, in the face of the severe economic situation, and coupled with earlier failures to address the situation through user fees, Ghanaian politicians had generally left health care financing to the bureaucrats (Coleman, 2011). In the absence of politicians' involvement, as Coleman (2011) notes, "technocrats began, for the first time, to significantly influence policy, particularly the organization and delivery of [health] services" despite the fact that the user fee model was clearly at odds with the ideology of the PNDC (p. 12).

According to Adibo (2013), the priority at the time was to develop a Legislative Instrument (LI) to guide the policy's implementation. In fact, as noted above, a policy of similar magnitude had been sent to parliament and passed in 1981, during President Limann's regime, when the government was overthrown by a coup d'état. In 1982, the MoH, led by Dr. Adibo, had also made a proposal to the PNDC to introduce user fees, which was rejected. This means that the ministry and Dr. Adibo had already gained significant experience in the development of user fees policy before the PNDC's decision to adopt them in 1983. Hence, what they basically did was to amend those earlier proposals (Adibo, 2013). Particularly, they changed the levels and composition of the fees, the exemption schemes, and the systems for managing the fees collected.

Various stakeholders in the health sector, including the GMA, regional directors of health, experienced theatre nurses and important medical doctors, among others, were involved in the design of the policy. The inclusion of these actors helped in generating a list of services and procedures relevant for the user fee policy, as well as the appropriate price tag for each of those services and procedures. As Adibo (2013) recounted during the interview,

I met the medical association and planning unit. First of all when the idea came, I discussed it at the meeting of regional directors... I told them what was going to be done, how it was going to be done.., but talking to doctors can be intimidating, so I dared not send a nurse or physician. I decided that I would do that myself. And I ... invited the heads of the various sections in the hospitals and they came and I told them what I wanted, so I got a list from them ... [they include] operations, major operations and something else. There were three things that we agreed on. They listed them and we met, they presented the list, and there was consensus that these are the activities to include in the policy.

Upon receiving the list of the various procedures to be included in the policy, the ministry then went ahead to cost them. For example, Adibo (2013) indicated how the cost for a caesarean procedure was established as follows:

In a theatre, there is a theatre nurse who makes sure that everything including swaps that were used in operating were there, so a theatre nurse can tell you that we need so much of this so much of that for one operation and you need to know these basic facts to be able to estimate the cost of operation. So I worked with nurses like that and the surgeons themselves before we arrived at the cost of each operation. [That was] because I wanted this to be very professionally done. So we did it and I had to ask them of the number of hours one could spend on a caesarean section for example. They told me. I knew their salary so [I could determine if] two hours of their salary was what goes into the costing. Then [I also asked, for example] the theatre nurse how many swabs, how much cut guards, how many of this how many of that was required. We wrote all those things down, cross checked with the surgeon. If he agrees, then we put cost to it. So I didn't sit in my office and conjure the figures. No! I got the data from them.

A similar data collection procedure was employed in identifying the specific drugs to be included in the policy. In this case, the one-man design team benefited immensely from experiences at the district hospital level and numerous trips made to Osu Oxford Street, one of the principal business centres in Accra, Ghana. As Adibo (2013) noted,

Having worked at the district hospital level, I wrote down the list of drugs with which anybody could run the district hospital effectively...I realized that prices were going up so I wrote down the most important drugs and once a month I went to Oxford Street. There were a number of pharmacies there and I had my yellow card. And I asked [for]

the drug and I asked how much is the drug? They told me and I wrote it down. What about this one, what about that one? And I was monitoring the price movement over time.

When everything was done, the ministry submitted its design to the PNDC government for approval.

The implication of the above is that, unlike that of the NHS system, design of the user fee policy was entirely performed by technical experts within the MoH, with no participation from the general public. Additionally, actors from other departments or sectors of the economy such as interest groups, non-profits, politicians and donors were ignored. This approach limited the opportunity for potential opponents of the policy to disrupt the design process. Hence, design of the user fee policy was carried out rapidly.

### **5.3.3. Adoption**

Because Ghana was under military rule, the adoption of the user fee model was expedited. Since the PNDC performed the dual role of cabinet and parliament during the introduction of user fees in 1983 and its amendment in 1985, opposition to the policy was minimized. However, some potential obstacles still remained. For example, as a socialist party, the PNDC had the tendency to keep the fee levels lower than needed. As Adibo (2013) noted during the interviews,

[Having] sat down with the professors in the medical school, some surgeons and [ascertained that] the cost of a major operation in those days would cost 10,000 cedis. When I presented this to them, the PNDC told me that the average Ghanaian cannot pay 10,000 cedis ... Eventually they said 1000, so I said, sir, what this means is that government is subsidizing the cost of operation by 90%. [Also, when] I said [or asked them] how much should foreigners pay? They said 1500 [cedis].

According to Adibo, the final document was prepared to account for the above changes.

Although from the quotation above, it appears the one-man design team was flabbergasted by the way the amendment was carried out, it should have been expected. Despite the crisis, it took some time for the PNDC to move away from its leftist ideals they had held

for several decades. As Grindle and Thomas (1989) emphasize, “in crisis-ridden reforms...technical analysis, bureaucratic interactions, and international pressures often assumes importance,...but usually remain subordinate to concerns about stability or survival of the regime in power or the longevity of its incumbent” (p. 232). Thus, the PNDC had to tread carefully. This might have motivated its decision to water down the professionally determined fees in order to protect itself from potential overthrow by opponents, including disgruntled party members.

Despite the grey area discussed above, the design team was able to dominate in other areas. For instance, the policy document stated that part of the fees to be collected should be kept within the respective medical institutions to be used for improving services and buying drugs. The PNDC disagreed vehemently with the design team on this issue because they thought that all the monies should be deposited into the National Treasury, as Adibo (2013) indicated,

Kwesi Botchwey was the minister of finance at the time. He asked me if the ministry of education too wants to keep the revenue they generated, what will happen to the government. So I said the two are not comparable. The two are different. We are not going to chop [misuse] it. We are going to put it in the bank so that when we need to import things, we can take the money from the Bank of Ghana [for it].

Campbell (2002) argues that in order to achieve a far-reaching policy change, the reformers must craft their policy ideas in a manner that could appease even potential detractors. Having framed the decision in the way that sought to support the health sector rather than any particular interest, the design team was able to get the government to approve their request. Hence, according to the user fee law, half of the fees to be collected should be delivered to the MoH (which included all the public medical providers), while the other half was to be deposited into the National Treasury.

The design team was also victorious in how much the drugs were to be sold for under the user fee policy. Again, as Adibo (2013) noted, the design team’s success in this area was due to how the idea was framed.



Fortunately for me, if you go and look at section 5, which deals with drugs, I said drugs could be sold at costs. My experience of the escalating price of drugs in the drug stores on Oxford Street was what gave me the idea to write drugs to be sold at cost so if you go and buy it for one cedi if you buy it at 5 cedis [then you sell it at that price]. So fortunately for me, nobody saw through this. They didn't argue. When the LI went to the PNDC it was approved.

Had the design team proposed a mark-up to the cost price of the drugs, it would probably have been rejected by the PNDC. This is because it would have sent a signal that the team was seeking to privatize the public medical care system, a move that would have definitely backfired given the socialist orientation of the PNDC government.

According to Béland and Orenstein (2009, p. 705; 2010, p. 630), in order for policy elites to pursue change, they must show that “change is necessary”. Through a series of questions I posed to the design team, it became evident that a sense of urgency and momentum for change existed. In the passage below, Adibo (2013) explains the team's framing strategies, which enhanced their proposal for change. As he notes,

We had a problem and I tell you as it is - take it or leave it. I know [I] am an advisor, but I must say that I had worked with PNDC secretaries who were very understanding. Maybe I know how to put my case convincing...As professor Bene once told me ... you the way you write things you have to take it. If you don't take it, you would look like a fool so you have to take it. So that's how I write.

From the above, it appears the team had significant levels of boldness and the ability to convince and so to influence the decision of the government. Interrogating this issue further in the interview, it came to light that usually the facts were embellished in a manner that tilted choices towards the preferences of the team. As Adibo (2013) noted when explaining the strategies he usually employed to convince the policymakers,

I state the fact, and I write it in such a way that if you don't see it, then it's a problem. I state my case very strongly ... When I am writing, I don't say that this is the way it should be done. [Rather], I tell you there are a number of ways to do it. If you do it this way, this will be the outcome. If you do it that way that would be the outcome. Then I ask you to look at the three options. I then decide that this is the best option. If you disagree then you can choose one.

The ministry representative was able to convince the PNDC to adopt the ministry's user fee proposal using this approach. He explained,

I told them how much there had been shortages - you go to the hospital even paper to write on [was not available]. So at one point we started asking patients to come with exercise books. So do you keep the exercise book or you give it to the patient? ...If the patient keeps it and doesn't bring it the next time you don't remember what you saw the patient for, so this wasn't helping the system. And so we need to run the system properly. So we need to charge minimal fees ... I set out how I arrived at the fees and so everybody saw that yes we had a problem maybe for now the immediate problem was to charge some fees whilst we think about the long term solution (Adibo, 2013).

Like the above lead actor of the ministry, many of the interviewees at the ministry acknowledged how much of their discussions and meetings with the PNDC were centred on making user fees a temporary rather than a permanent policy (Adjei<sup>31</sup>, 2013). That frame may have also contributed to convincing the PNDC to shift their policy direction while they searched for a permanent solution to the health care problem later.

The design team's proposal was also accepted because of the fee exemptions provided for indigents, pregnant women, the aged and children, as well as for those suffering from diseases like tuberculosis and for immunization services. The incorporation of the exemption clauses suggested that the marginalized, who formed a significant base for the PNDC, would not suffer under user fees. Because it was a mere political strategy, not much attention was paid to the determination of the exact content of the exemptions or their implementation. For instance, the team did not attempt to estimate the number of people the exemptions were likely to cover. As Adibo (2013) noted,

We said government would refund to any health institution the cost of treating the poor and the destitute. So one day Kwesi Botchwey [Finance Minister] called me and said what percentage of your clientele is made up of the poor and destitute?...That is when I learnt that Ghanaians don't like taking decisions. When they asked me I called the regions, but nobody had done it. Only Korle bu had done it at the time and they said 10% of their clientele were classified as poor and destitute so I told Kwesi Botchwey that maybe for the time being let's use that for the nation but I will try and see if I can get the [the rest but] I never got any so we still don't know that one for sure.

In addition to the marginalized, health care staff were exempted from paying user fees under the user fee policy to encourage them to collect the fees on behalf of the government (Adibo,

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<sup>31</sup> Adjei was involved in the racking or monitoring of the implementation of the user fee policy.

2013). Because the exemption package was politically motivated, it could not be effectively implemented. The next section provides more details on this issue.

#### **5.3.4. Implementation**

Grindle and Thomas (1989) note that agenda setting and formulation are simply the genesis of policy change. The actual work of policy change resides in implementation, where reformers tend to face their main opponents. In order to successfully navigate through the rocky politics of implementation, it is argued that political leadership is required (Gilson & Di McIntyre, 2005). With respect to a more contentious issue like user fees, as Kajula, Kintu, Barugahare and Neema (2004) note, “the reforms must be owned and directed by the central government” (p. 151). The importance of having the support of the central government is that apart from having the ultimate power to pursue change, as politicians they also have the tendency to withdraw from doing so when facing significant opposition. This happened under Ghana’s NLC military regime in 1968/9 (Arhinful, 2003) and also in Uganda in the early 2000s (Kajula et al., 2004). It appeared the design team did a great job in getting the PNDC on their side. As Adibo (2013) acknowledged,

The PNDC secretary launched it [the user fee policy] on radio and TV... immediately after that we had a discussion on “talking point”, [a Ghanaian Television program]. I appeared on it [“talking point”] to explain it [the user fee policy] and defend it. When the government accepts these things they don’t run away from it.

Thus, the PNDC went beyond the adoption stage to showcase the policy on national radio and television followed by public education, with Dr. Adibo at the forefront. Given that they had nationwide coverage, the media offered a significant opportunity for the PNDC and the ministry team to shape public perception about the content of the new policy. Adams<sup>32</sup> (2013)

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<sup>32</sup> Mr. Adams is an officer at the Ministry of Health. During the transition to the user fee policy, he was then working as a public health officer at the regional hospital in Accra.

also noted that other sensitization programs were held for the general public on the fees. Thus, as he emphasized, “so people knew that when they came for service, they had to pay”.

Thereafter, information was passed on to the various regional offices and health facilities in the country to implement the cost recovery policy. The content of the policy, as hinted above, included charging users for the costs of drugs, consultation, diagnostic procedures and other services as enshrined in the law. Also, fees were supposed to be based on service level (i.e., health centre or hospital), treatment location (urban or rural), age (child or adult), service type (curative, preventive, disease or procedure), and nationality (Ghanaian or non-Ghanaian). Thus, health centres were supposed to charge lower fees than district hospitals, district hospitals were also supposed to charge lower fees than regional hospitals, which, in turn, were to charge lower fees than teaching hospitals (Waddington & Enyimayew, 1990; Asenso-Okyere; 1995). Compared to those in rural areas, facilities in the urban areas were required to charge higher fees, while adults were also made to pay higher fees than children. Additionally, while postnatal and prenatal services for pregnant women and care for people affected by diseases such as leprosy and tuberculosis were exempted from all fees, people battling with communicable diseases such as typhoid, schistosomiasis, viral hepatitis, tetanus and cerebrospinal meningitis were only exempted from the care provided. They still had to pay the cost of the drugs provided, which, indeed, was a significant share of the costs of medical care (Waddington & Enyimayew, 1989; Asenso-Okyere; 1995).

However, systematic studies of the implementation process (Waddington & Enyimayew, 1989, 1990; Asenso-Okyere, 1995; Coleman, 1997; Nyonator & Kudzin, 1999) revealed that some marked changes occurred at the stage of implementation. For instance, it was observed that beyond the legal fees above, patients were paying unauthorized fees, some of which amounted to 700% above the amount stipulated in the law.<sup>33</sup> Also, the clauses

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<sup>33</sup> Much of those extra billings flowed into the pockets of providers.

emphasizing price disparities between rural and urban dwellers and hospitals and health centres were not implemented precisely. In addition, there were multiple payment points, which encouraged bribery in the health care facilities. Many customers were also not issued receipts for the services they purchased. Asenso-Okyere (1995) also noted that, on average, children paid between 50% and 67% of the fees paid by adults, while foreigners paid between 133% and 267% of the fees paid by Ghanaians. Above all, revenue mobilization rather than service improvement became health facilities and professionals' overriding concern (Coleman, 1997; Nyongator & Kudzin, 1999).

According to the user fee policy, 50% of the fees collected were to be returned to the Government Treasury, while the MoH would retain the remainder<sup>34</sup> (Demery et al., 1995). Health facilities were also required to deposit all monies collected in a central account in order for them to receive drugs and other medical supplies from the central medical stores through its regional branches (Coleman, 2011). When the fee levels were raised or amended in 1985 (through LI1313), however, both district and regional hospitals could retain 50% of their collections, while health centres retained just 25% of their collections (Demery et al., 1995; Coleman, 2011). Over time, particularly after 1990/1992, the government agreed to forego all its own revenues from user fees, which led to the facilities retaining all the fees collected (Demery et al., 1995; Coleman, 2011). At the same time, however, as Adjei (2013) and Adams (2013) noted, the facilities continued to receive drugs and pharmaceuticals from the central medical stores, the purpose of which was to allow them to build seed capitals to payback any drug they had been supplied (Adjei, 2013; Adams, 2013). However, the arrangement bred a significant level of corruption on the part of the providers, as “only 10% of the cost of input

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<sup>34</sup> The service providers collected the fees directly and transferred them to the MoH. Upon receiving the fees into its general revenue account, which was separate from that of the Treasury, the Ministry then transferred the share of the Treasury. Administratively, this led to corruption on the part of the providers, as not all the monies collected were accounted for.

[which they received from the central medical stores was]...actually...paid back” (Adjei, 2013). This problem, among others, culminated in the idea to “introduce a system whereby you [the providers] go and pay...and collected your [their] medicines” (Adjei, 2013). This system led to the concept of cash-and-carry or pay-before-service in the Ghanaian health politics.

The cash-and-carry system was first piloted in the Greater Accra Region and was extended to the other regions of the country in 1992, when an official amendment to that effect was enacted. Interviewees typically stressed that the cash-and-carry system enabled them to purchase drugs from the central medical stores or even the private sector, reducing the bureaucracy involved in obtaining drugs under the previous system (Adams, 2013; Adjei, 2013). Also, the facilities were able to replenish drugs whenever they were depleted. As a pharmacist at the regional level at the time emphasized, “we didn’t run short of drugs and nondrug items” (Adams, 2013). It also freed health facilities to purchase drugs from either the central stores or the private sector. That way they were able to purchase drugs from the most cost-effective source (Adjei, 2013). Additionally, it changed “management perspective and style of operation of the hospitals”; with the new policy, they could generate and manage their own resources rather than depending on the government for resources that, in reality, were hardly available at the central medical stores (Akosa, 2013). Additionally, as Adams<sup>35</sup> (2013) indicated, “even when equipment broke down, we had money from the cash-and-carry to repair”.

However, the cash-and-carry approach made health care expensive, resulting in a significant underutilization of the public health care system (Agyepong, 2013; Nortey, 2013). For example, while it was clear in the law that providers should grant exemptions to those entitled to them, that part of the law was ineffectively implemented (Seddoh, 2013). The

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<sup>35</sup> In the 1990s, Mr. Adams was then working at the central office of the Ministry of Health. As the key person behind the formulation of the cash-and-carry, he is generally referred to by his colleague in the Ministry of Health as the architect of the “Cash and Carry” policy.

reasons for the ineffective implementation of the exemptions were all at once design-based and administrative. Design wise, as Adams (2013) noted, the “guidelines were not adequately spelt out. For example, if children under five are to be exempted, for what? Everything?” Also, although the law was clear on who and what to be exempted, it did not specify who would pay for the exemptions (Adams, 2013; Arhinful, 2003). This gap created confusion for those in charge of implementing the exemptions. As Adams (2013) noted, “we don’t have any business giving free services, somebody should have to buy the service for the poor”. Also, the authority to exempt was vested in the provider staff at the top hierarchy rather than the frontline bureaucrats in the healthcare facilities. Hence, beneficiaries had to go through a chain of bureaucratic procedures before they were exempted (Awithey, 2013). In fact, the lengthiness of the process frustrated and deterred potential beneficiaries from using the exemption scheme (Agyepong, 2013).

The failure of the exemptions was also ideationally driven<sup>36</sup>. For example, as Adams (2013) revealed, “I am providing a service and then I’m generating funds based on the service...and the same time you want me to exclude some people from paying ... we are not a social welfare institution, we are a service-oriented institution. So if you ask us to provide the exemption, we were hopeless at that, we couldn’t do it, even though we were trying to implement it”. This belief may have been aggravated by the cash-and-carry system. As Adjei (2013) indicated, “hospitals became so much focused on recovering their seed capitals” rather than improving the medical conditions of their patients. Another factor that may have contributed to the failure of the exemptions was the subculture, referred to as “*kalabule*”, which emerged during the economic crisis when everyone tried as much as possible to cheat their counterparts out of the hardship<sup>37</sup> (Adjei, 2013). It is argued that the policy made some doctors

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<sup>36</sup> Those responsible for implementing the exemptions did not even believe that it was their fair share of responsibility to cover the costs for these exemptions.

<sup>37</sup> During *kalabule*, most sellers take advantage of buyers by inflating prices of their products.

and facilities inflate the costs of services in order to replenish what they may have lost to personnel outside their health facilities.

As a result of the above problems, additional changes to the policy were made at the level of implementation. For instance, minimum deposits were instituted in the provider facilities so that inpatients had to bear those costs before being offered treatment (Agyepong, 2013). Also, the exemption scheme was often not implemented. For example, as Nyonator and Kudzin (1999) observed, less than one in a thousand patients were exempted by most facilities in the Volta Region in 1995. Also, the majority of the exemptions (71%) went to health care staff rather than to the marginalized, who needed them most. In particular, the facilities charged for the costs of drugs and consultations for antenatal care, although they were supposed to be offered free of charge under the user fee policy. In addition, the introduction of unofficial fees became a widespread phenomenon in the mid-1990s.



**Table 4 Changes to the user fee policy at implementation as of 1997 in a number of facilities in the Brong Ahafo Region.**

<i>Stipulated prices compared with mean prices charged in government district hospitals</i>			
<i>Service</i>	<i>Stipulated price</i>	<i>Mean price</i>	<i>% increase</i>
Outpatient	50	350	600
Inpatient	100	325	225
Delivery	100	2000	1900
X-Ray	200	2000	900
Urine	40	575	1338
Caesarian	1000	55000	5400
Hernia	500	28333	5567
<i>Proportion of Facilities Charging for Consultations and Laboratory for Specific Exempted Illnesses</i>			
<i>Disease</i>	<i>Fee type</i>	<i>Regional hospital</i>	<i>District hospital</i>
Measles	Consultation	0/1	10/11
	Laboratory	1/1	6/11
Typhoid	Consultation	0/1	11/11
	Laboratory	1/1	11/11
Hepatitis	Consultation	0/1	11/11
	Laboratory	1/1	11/11
Tetanus	Consultation	0/1	11/11
	Laboratory	1/1	11/11
Sickle Cell	Consultation	0/1	11/11
	Laboratory	1/1	11/11
<i>Percentage Of Government Facilities Charging For Exempted Supplies By Level</i>			
<i>Item</i>	<i>District hospital</i>	<i>Health center</i>	<i>Rural clinic</i>
Gauze	81.8	78.3	90.0
Plaster	63.6	75.0	80.0
Gloves	90.9	70.0	77.8
Antiseptic	33.3	52.4	44.4
Needles	90.9	87.0	90.9
Syringe	81.8	78.3	90.9
Bandage	81.8	70.0	60.0

Source: Coleman (1997, par 19-29)

As indicated in Table 4, above, the cost of delivery, which was officially pegged at 100 cedis was being offered for 3000 cedis (an increase of 1900%) in some district hospitals. Services such as Caesareans were provided at 5400% higher than the official cost in some hospitals. Patients were required to pay for medical consumables such as plaster, gloves and bandages etc., which were supposed to be provided for free under the law. These examples demonstrate the extent to which the user fee policy was changed at the level of implementation. This confirms Grindle and Thomas' (1989) argument that "the distribution of implementation outcomes is not bi-modal" (p. 235). That is, beyond the possibilities of it succeeding or failing,

the implementation process could also result in a third possibility of significant policy change. The changes that occurred during the implementation of the user fee policy was so remarkable that one could hardly compare the official policy with the one under implementation.

An inquiry into the causes of the change revealed an interesting result. As suggested in the passage below, much of the blame should be put on the PNDC for failing to agree to revise the fee levels over time. Adibo (2013) noted,

For years nobody ever varied the fees. The institutions themselves started it. I wasn't happy with that so I went to [the ministry of] Finance. The present vice president [Amissah-Arthur] was the deputy minister of finance at that time, so I went to him...He was my friend so I went to him and I said since 1985 July the fees have remained the same. Now institutions are introducing their own fees and it's not nice so we want your authority. He said why don't you do it like Electricity Corporation, bit by bit...and [that] our operation would cost so much...But I had thought that we would sit down and review the whole package so that we would make amendments and then it would be approved and the minister would sign that is how I thought it would be but he didn't want us to do it that way.

Further inquiry into the government's decision also showed that some of the members were also afraid of potential reprisal from other members. In answering why the above deputy minister preferred an incremental approach to the fee change, Adibo (2013) declared,

Because he didn't want to face the PNDC. [*Despite the fact that he himself was a member of the PNDC?*]. Yes but when the whole team meet, you don't know what the other members - about 20, 21, 25 - would say. And then if they ask me why have you brought this thing and I say I consulted the deputy minister of finance, I will be putting him in trouble... So he was playing it safe.

The implication here is that although the PNDC was aware of the problems with user fees, it was not interested in increasing the fees. What was even more surprising about the issue was that those responsible were allowed to go scot-free, despite the significant power and opportunity the regime had to enforce compliance with the law.

However, a MoH circular concerning unofficial charges at the facility level suggested that the ministry might also be blamed for the situation. For instance, as the circular indicated,

This policy of providing free medical consumables to the health institutions appears not only outdated but economically unbearable to the system since it is a fact that almost all the institutions have been charging patients for these same items (MOH, 1997 cited in Coleman, 1997, "study area", par. 6).

My analysis with respect to the government and MoH's toleration of the unofficial charges is that it was probably part of their strategy to escape blame for increasing the fees. This approach can be related to Jacob Hacker's (2004) conception of policy drift as "changes in the operation or effect of policies that occur without significant changes in those policies' structure" (p. 246). Policy drift involves a change in the policy context as a result of the inability to pursue formal changes. In Ghana, however, both the Rawlings regime and the MoH had the opportunity to change the fees, but just decided to do nothing. In the long-run, this strategy can derail the sustainability of the policy, an issue that is the focus of the next section.

#### **5.3.5. Sustainability**

Sustaining the policy was difficult, as it led to a significant reduction in access to health care throughout the country. As Awithey (2013) notes, "the poor couldn't access health care which was supposed to be affordable and accessible...Because of their financial status, it has become unaffordable and inaccessible to them". Consequently, "utilization dropped" propitiously (Adjei, 2013). Seddoh (2013) confirmed this, arguing that only "0.3 or 30% of the population was actually using services which was way below the globally accepted norm of one". Academic studies have also revealed that the user fee policy was very unpopular among the general public. For example, in their study involving 306 households in the Eastern Region of Ghana, Asenso-Okyere, Osei-Akoto, Anum and Appiah (1997) found that about 80% of the households were displeased with the user fee policy. Arhin (1994) observed a similar situation in Osudoku sub-district, where most household heads were also dissatisfied with the policy.

Despite its unpopularity and the regressive manner in which it was implemented, the user fee policy was sustained until the early 2000s, when it was officially abolished. The common answer from interviewees as to why this was the case was that the implementation process faced little opposition, even from the TUC, which is noted for its vibrancy at protecting

the interest of its members even under authoritarian regimes (Hutchful, 2002). Although they were aware that the user fee policy was problematic for their members, the TUC generally failed to directly attack the policy through street demonstrations as they had done in similar situations in the past (Herbst, 1991; Jefferies, 1991; Hutchful, 2002). Instead, it decided to battle the policy through indirect means such as conference presentations and media statements, which failed to yield any real benefit for them (Herbst, 1991; Jefferies, 1991; Hutchful, 2002). For example, the TUC issued a statement at its Third Delegates Congress at the University of Cape Coast in March 1988. They argued, among other things, for the “restoration of free education and universal health care” (Hutchful, 2002, p. 174). Using this kind of approach to convey their grievances to government was uncharacteristic of the labour movement in Ghana, which is noted for its radicalism (Hutchful, 2002). Indeed, “a lot of them [the labour unions] took [upon themselves] the responsibility of providing [health care<sup>38</sup>] for their members” (Akor, 2013). The implication is that labour basically acquiesced to the government, resulting in the continuation of the user fee policy despite its detrimental effects on members. Another group of stakeholders that had a successful record of opposing user fees was the military. For example, as indicated, they overthrew both the Busia and Limann governments, in 1972 and 1981 respectively for reasons that included the user fee policies of the governments. These military takeovers, resulted in the inability of the governments to implement their user fee policies (Coleman, 2011). The final group involved the general public, who basically decided to exit the health system rather than make direct opposition to the policy (Adams, 2013).

But after having been so powerful in the past, why was opposition against user fees ineffective in the 1980s? For instance, whereas past attempts to introduce user fees had been thwarted by resistance from civil and military groups, why did their efforts fail to prevent the

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<sup>38</sup> An interview with an officer of the TUC confirmed that they established community-based health insurance schemes for their members in order to cope with the hardships posed by the user fee policy (CSO 03, personal communication, March 27, 2013).

adoption of the user fees in the 1980s? Why did labour groups fail to directly attack the user fee policy at that time? Though the PNDC only intended to implement user fees only temporarily, why did they fail to withdraw the policy when it had become clear that the policy was not serving its intended purpose?

One key factor lies in how user fee politics played out between opponents (workers, the general public, opposition political parties and the army) and proponents (the PNDC government) of the policy. Overall, through political leadership, underground tactics (policy drift), framing and repression, the PNDC was able to shield the entire society and, by extension, the health care system from the kind of politics that led to the collapse of the user fee proposals of the past. First, as indicated, although the policy was designed by the MoH, the introduction of user fees was first publicized only in the PNDC's April 1983 budget. Hutchful (2002) summarizes the key aspects of the 1983 budget, which includes the introduction of the following:

(a) a system of export bonuses and import surcharges ranging from 750% to 990%...(b) an increase in the cocoa producer price from 360.00 cedis to 600.00 cedis per load of 30kg.; (3) increase in the minimum daily wage from 12.00 cedis to 21.19 cedis and (4) increase in the price of fuel (100% in the case of petrol), in medical fees (up to 1,500%), and in the price of meat and other basic consumer items (up to 500%). (p. 36).

The significance of using the budget process to foster the health care reform is that it channelled opponents' attention towards challenging the broad economic policy of the government, including education, health care, devaluation, pay, subsidy, jobs etc. (Adibo, 2013). Opponents were forced to address almost every problem in Ghana at one time, making them unable to pursue their interests effectively. Consequently, this created the perception that they were opponents of the regime rather than actors that were pursuing a genuine interest of their members (People's Daily Graphic April 27, 1983, cited in Herbst, 1991, p. 182). Viewed as opponents of the regime, these actors put themselves in a position of incurring the displeasure of the PNDC. The Secretary of Finance also reportedly labeled opponents as "disloyal" (People's Daily Graphic April 27 1983 cited in Herbst, 1991, p. 182).

Through rhetoric, the PNDC leadership also attempted to generate support for the policy. In his defence of the budget on radio and television, the chairman of the PNDC, Rawlings, for instance, tried as much as possible to align the goal of the policy to the public interests of the country as a whole. He stated,

Only a government which places the interest and the very survival of the nation before its own interests would have come out with such an austere budget. If the PNDC Government was concerned with cheap popularity, we would not have presented you with such a budget. The medicine is bitter, I agree, but it is necessary (Rawlings 1983, p. 16, cited in Jebuni, 1995, p. 36)

When the PNDC's rhetoric failed to quell opposition to the policy - that is, two months after delivery of the budget - Rawlings shifted from merely expressing his commitment to the budget to also declaring his readiness to crush opposition, no matter how much it took to do so. He declared,

We may anticipate that soon the floodgate of protests against human rights violations will be opened as the next tactical move of organized hypocrisy, but for the defence of our revolution we will run that risk. If we must use our strength to crush actions which threaten the process so be it (Rawlings 1983, p. 25, quoted in Jebuni, 1995, p. 33).

Thereafter, the government resorted to violence and intimidation against opponents of its policies. Ninsin (1991) notes,

The government relentlessly festered out and detained or intimidated critics and organized opposition within the Trades Union Congress (TUC); radical organizations such as the New Democratic Movement (NDM), the Kwame Nkrumah Revolutionary Guards (KNRG), and others that operated clandestinely or from exile; and the National Union of Ghana Students (NUGS), the students organization based in the country's three universities (p. 55).

The government also sought to divide unions in order to prevent them from launching a common attack against the government's policies. Ninsin (1991) commented that,

As punishment for potential critics and opposition groups within the labour movement, the government pursued a policy of denying some Unions access to resources under the ERP while giving preferential treatment to others by improving salaries and benefits or assuring them access to resources under the ERP. The Civil Servant's Association, the railway workers, the mine workers have benefited from such special treatment as has the Ghana Private Road Transport Union (GPRTU). The first three of these workers' groups have a tradition of militancy (p. 55).

By trying to oppose everything that was included in the budget, the labour unions could not also build the requisite consensus to effectively oppose the user fee policy. For instance, when some of the aggrieved members of the TUC launched a coup on June 19, 1983 – and almost deposed the government - “the WDCs [Workers Defence Councils]<sup>39</sup> mounted roadblocks and rallied to support the regime” (Herbst, 1991, p. 181). On 4 June 1987 and 9 May 1988, the TUC’s Hall of Trade Unions was also blockaded by groups of workers that reportedly had allegiance to the PNDC, such as the Progressive and Militant Workers of Ghana and the defence committees. Finally, as Hutchful (2002) wrote,

Militant union leaders were subjected to frequent attacks and vilification in the government controlled media; at the same time close control over the media isolated the union’s leadership and prevented it from presenting its case to the public (p. 176).

This was also confirmed during the interviews, as Akanzige (2013) said,

Labour groups had been cowed...in Ghana. Rawlings era was dictatorship. Even Rawlings ...constitutional era (1992-2000) was a constitutional dictatorship. Because of his era, from 1992 everybody was afraid of him.

The PNDC also silenced opposition political forces in the country by banning their activities (Afriyie, 2013). It also created a “culture of silence” where critics were arrested, detained and molested. For instance, the head of the political department of the TUC, K. Adu-Amankwah, was picked up in 1987 and detained for opposing the policies of the PNDC (Hutchful, 2002). These actions bred fear, as Professor Adu-Boahen, who became the candidate of the opposition political party in 1992, confirmed in his 1988 Danquah lectures. He said,

We have not protested or staged riots not because we trust the PNDC but because we fear the PNDC! We are afraid of being detained, liquidated or dragged before the CVC or the NIC or being subjected to all sorts of molestation (quoted in Jeffries, 1991, p. 169).

But the violence was not directed towards only unions and political organizations; almost everybody was threatened. As Herbst (1991) indicates, “it was clear that even the

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<sup>39</sup> The WDCs were formed by employees of businesses across Ghana in support of the PNDC’s effort to revolutionize the country. They were supposed to help the PNDC to wrestle power from the elites to the commoners.

ordinary person was susceptible to repression” (p. 183). A PNDC official confirmed this when he said, “the message gets down that if you do something against the regime do not expect a lawyer to get you out of jail. The regime will only trial you when they get around to it” (Herbst, 1991, p. 182). Awithey (2013) confirmed the above situation during the interview. He argued,

At that time, the system was not as democratic as we have now. So people could not walk on the street. But you could see the sentiments of people in the form that they could not afford the user fees and so they stayed home. That was the silent probably sentiments that you could observe... You didn’t find people on the streets that were protesting but they couldn’t afford and so that was also the worrying factor. Because then there were people who were going to remain with their disease without having access to care.

Furthermore, military personnel believed to be opposed to the regime’s policies – most of whom were leftists and so felt betrayed by the PNDC – were molested, detained, executed or purged, while many others were kept under strict surveillance (Hutchful, 2002, p. 47). The army’s command structure was also reinvented and parallel military groups were formed and empowered to monitor the activities of de jure military body. Some of these groups include the Armed Forces Committee for the Defence of the Revolution (AFCDR), which basically served as a PNDC wing within the military. The others included the Forces Reserve Battalion and the Civilian Militia, which were basically established outside the military to provide to check on the military. After the failure of the June 1983 coup attempt, the PNDC made sure that the armed forces were briefed on all initiatives before implementation in order to gain their support (Hutchful, 2002). Also, as Hutchful (2002) indicated, “a dialogue was subsequently maintained with the armed forces, with durbars [official meetings] to educate and inform the forces, attended by government secretaries and other officials, being held with some regularity at Burma Hall and in the barracks” (p. 48). Finally, within the PNDC, Rawlings ensured that he was surrounded by trusted associates, such as Kojo Tsikata, Tsatsu Tsikata, Kofi Awoonor, Major Quarshigah and Obed Asamoah, who were from his ethnic group (Hutchful, 2002). These trusted associates served as a shield for the regime and, by extension, its policies.



The PNDC and adherents of user fees, such as the IMF, the World Bank, and the public service, particularly the MoH and the Ministry of Finance, maintained a close relationship, which may also explain why the policy was sustained overtime. As Afriyie (2013) noted during the interview, “it was between the devil and deep blue sea and, this IMF and World Bank, they were going to pull the plug [if the government had refused to carry on with the policy] so it had no choice”. For example, the World Bank put pressure on the PNDC to continue implementation of the user fee policy in its formal report on user fees. The report, titled *Agenda for Reform* (1987), detailed the Bank’s plans and support for user fees in developing countries. In Ghana, as elsewhere in the developing world, the World Bank continued to support user fees even after UNICEF (1987) had revealed that they were unsustainable. Instead, in response to the UNICEF study, and together with the PNDC, the Bank introduced a Program of Action to Mitigate the Social Costs of Adjustment (PAMSCAD), which basically focused on helping the vulnerable to cope with the governments’ market-based policies, including user fees (Adibo, 2013). The PAMSCAD, however, was not effectively implemented, leading to its failure (Hutchful, 2002).

Additionally, because the user fees provided a reliable source of revenue for the health sector, the MoH and the service providers at large were stuck with it (Nyonator & Kudzin, 1999). For instance, in their study involving some health centres in Ghana, Waddington and Enyimayew (1989) observed that “in no case did a health centre worker say that it would be good to return to a free health service, though they did acknowledge that fees caused patients to present rather later with their illnesses than they might otherwise have done” (p. 22). The potential vested interests of these actors may explain, at least partly, why they (together with the World Bank and the IMF) persistently framed alternative health financing measures like health insurance as being “impossible” in Ghana and why the PNDC’s efforts at introducing such policy after 1987 generally failed (Amoh, 2013). For example, having been charged with

introducing health insurance, the MoH launched committee upon committee and study upon study until the agenda finally fizzled out (Amoh, 2013).

#### **5.4. Causal Interactions**

In this section, I will summarize how particular causal factors interacted over time to ensure the adoption and implementation of user fees in Ghana, in spite of countervailing factors such as vested interests supporting the status quo. First, the introduction of the user fee policy was largely triggered by a decade of economic crisis, which, in turn, led to the 1981 coup that brought the PNDC military government to power. Over time, the crisis affected various sectors of the Ghanaian economy, including health care, compelling the need for change. In the process, user fees came on the political agenda through proponents such as the MoH, the GMA and the PSoG. In fact, MoH officials went the furthest in their support of user fees by developing a memorandum proposing the introduction of user fees. However, because of its left-leaning ideological orientation, the government rejected their proposal. Instead, it introduced measures in line with its ideology, including surcharges on import licencing and primary health care related schemes. It also attempted to solicit assistance from the Eastern bloc. However, all these measures failed. This difficult situation was compounded by the 1983 deportation of about a million Ghanaians from Nigeria, where they were allegedly living illegally. Having realized the gravity of the situation, the government then backtracked from its earlier stance by listening to alternative ideas, which brought user fees proponents such as the MoH and the IMF and the World Bank to the forefront of the policy discussion. At that time, however, the World Bank and the IMF were the most appealing not only because they had a more coherent agenda for economic reform, but also because they had the loan money the government needed. By getting user fees onto the governmental agenda, the IMF and the

World Bank made them part of their policy recommendation (SAERP), which, in turn, became a condition for further assistance to the government.

The MoH was responsible for designing the user fee policy. The MoH, as indicated above, was a key proponent of the policy, with the head of the Policy and Planning Unit, Dr. Adibo, leading the process. Having led similar processes in the past (1981 and 1982), Dr. Adibo was seen as the most appropriate person for that task. As the key policy entrepreneur and one-man design team, he determined the content of the policy and which other actors would be involved in the design process. He performed these tasks based on his own expertise and experience, as well as, by drawing lessons from earlier models the country had implemented. For instance, his experience at the district level and outside the health sector proved helpful in determining the kinds of drugs that should be covered under the policy and the price at which they should be sold. Where his expertise was limited, he solicited the assistance of other actors with such expertise. He also gleaned much information from prior policies, such as the 1971 legislation and the 1981 and 1982 proposals on user fees. For example, the decision to exempt the poor was shaped by the above legislations. However, the idea to exempt health care staff was largely shaped by the perceived need to encourage them to collect the fees. Having occurred within an atmosphere of neo-liberalism, it was also possible that the decisions of the design team would be influenced by the neoliberal doctrine at the time (Wireko & Béland, 2013). In this respect the notion to exempt, mostly, the marginalized such as indigents, children and pregnant women should be driven by the neoliberal doctrine that welfare policies should be targeted at the vulnerable groups in society (Adesina, 2011; Haque, 2008; McCoy & Peddle, 2012; Mkandawire, 2001).

After the initial policy was designed, the MoH, once again led by Dr. Adibo, submitted the draft user fees proposal to the PNDC for approval. This stage was also marked by an interaction between the institutional configuration of the state at the time, the ideology of the

government, and the strategies of the ministry's reformers. The authoritarian nature of the political system shortened the adoption process by removing the stage of Parliamentary approval, which could have delayed the process. Despite the fact that the concentrated nature of Ghana's political institutions at the time favoured adoption, the reformers still had to deal with the government and its ideology. As a socialist government, the PNDC insisted on watering down key aspects of the ministry's proposal in order to protect the marginalized, which formed its support base. However, by making those changes, the PNDC was also trying to mitigate the potential for resistance, thus drawing lessons from how earlier measures of a similar magnitude had failed. Despite these obstacles, the ministry's team managed to convince the PNDC to adopt a user fee policy that changed the trajectory of the existing health care system significantly (Waddington & Enyimayew, 1990).

Although the MoH was still involved, actors at the point of delivery, rather than at the ministry's head office, implemented the user fee regime. They included clinics, health centres, hospitals, facility managers, medical doctors, nurses, pharmacists and so forth. How these actors performed their respective roles led to further changes in policy. For instance, the practice of charging fees above and beyond the stipulated levels, introducing additional fees, and charging people for services that should have been exempt became widespread. The situation occurred as a result of a confluence of factors, including deficiencies in the law, administrative inefficiency, contextual changes, ideational factors and reformers' strategy of allowing such changes to occur without being noticed. These align with Hacker's concept of *policy drift*. According to Hacker (2004), policy drift can be a subtle way to pursue a significant policy change, especially when a formal policy change appears unlikely.

Despite ultimately being regressive in nature, the user fee policy was sustained longer than expected. Investigations into why reveal the interactive role of vested interests, institutions, political ideology, policy legacies and the strategies of both reform proponents (the

government, the Ministry of Health and the IMF and World Bank) and opponents (labour unions, political parties, actors from the left of the political divide, including in the military, and the general public). For instance, new constituencies developed among beneficiaries (legal and illegal) of the policy, including provider facilities and staff, as well as that fraction of the general public who experienced some improvements in their health care conditions as a result of the new policy. The centralized institutional configuration of the state also minimized the potential for opposition, while empowering reformers. However, the above factors largely facilitated rather than determined the outcome of the policy change. For example, the concentrated nature of Ghana's political institutions created a wide window of opportunity for reformers to employ all possible strategies – even repression – to pursue the policy change. Because of their vested interests in the user fee policy, the MoH and the IMF and the World Bank also consistently described an alternative policy like health insurance as impossible for a developing country like Ghana. The World Bank and the IMF also introduced PAMSCAD in order to mitigate the costs of the policy on the marginalized, who formed the largest base of the PNDC. The above reasons, among others, led to the sustainability of the user fee policy through time.

### **5.5. Theoretical Implication of the Change to User Fees**

The foregoing discussion is consistent with the theory of actor-centred institutionalism, particularly as Kingdon (2003) and Grindle (2004) posit. It shows how policy change may be moderated by interactions among politico-economic factors and actors across different stages of the policy process: problem definition and agenda setting, design, adoption, implementation and sustainability. While they seem to be independent of one another, these stages are interrelated. That is, an issue on the policy agenda sometimes influenced developments at subsequent stages. Similarly, the political temperature at the adoption stage could shape how

policy was implemented, which, in turn, could impact its sustenance. For example, because the fees were watered down on ideological rather than technocratic grounds at the adoption stage, actors at the implementation stage neglected those fees and introduced their own unauthorized fees, which were charged on top of the official fees. Also, the policy's positive effect on beneficiaries at the facility level generated a strong constituency around its sustainability.

The analysis also revealed the extent to which the transition process occurred within an atmosphere that was characterized by context-specific politico-economic factors and actors, including institutions, the economic crisis, vested interests, political ideology and policy entrepreneurs. However, the contextual factors influenced rather than determined key policy entrepreneurs' choices. For instance, in relation to Kingdon's (2003) framework, I found that the economic and health care crises created a window of opportunity for various actors to propose policy change, in this case the introduction of user fees. However, in line with Grindle's (2004) model, the ideological orientation of the government structured the way the PNDC regime approached the proposed policy change. In particular, the government's socialist orientation led to both the rejection of user fees when they had been proposed before and the watering down of their levels at the adoption stage. The socialist orientation of the government may have also mediated in the PNDC's decision not to increase the fees through official processes, leading to policy drift. Similarly, the concentrated nature of Ghana's political-institutional configuration minimized the opportunity for labour groups to prevent the adoption of user fees, while giving the government the leeway to repress opponents of the policy. Also, the failure of previous populist measures to address the situation and the subsequent aggravation of the economic crisis contributed to the appealing nature of the proposal of the IMF and the World Bank, among others, to push the government to backtrack from its earlier stance against user fees. Although user fees were part of the conditionalities of the World Bank and the IMF, whether or not, and how, they were implemented depended significantly on the

evaluations, decisions and strategies of domestic reformers at various stages of the policy process.

The transition also shows that not all the reformers or policy entrepreneurs were crucial at every stage of the policy process. For example, although it was a significant actor across all stages of the policy process, the PNDC government was not a principal actor in setting the agenda, which was largely the result of the work of the MoH, the World Bank and the IMF. That said, while they were significant at the agenda setting stage, the World Bank and the IMF were almost entirely absent from subsequent stages of the policy process, particularly the design, adoption and implementation stages, which were mainly shaped by the design team, the MoH and the PNDC government. As well, while the implementation stage was largely shaped by the MoH and service providers, the sustainability stage was largely the result of the efforts of the government and vested interests, including the MoH and the IMF and the World Bank. Thus, while policy entrepreneurs were crucial in the success of the reform, different policy entrepreneurs were critical at different stages of the policy process. This observation confirms Grindle's (2004) argument that policy change should be explored beyond the agenda setting stage.

In her study, Grindle (2004) suggested that socio-cultural factors shape the strategies, motivations, characteristics and actions of policy actors, which contradicts the popular argument that these factors determine policy change (Wilsford, 1994; Weyland, 2008). This study observed that the socio-economic environment cannot be trivialized as just shaping the strategies of the policy actors, as they also created a window of opportunity for policy change. However, even during windows of opportunity, contextual factors alone do not determine policy change. For example, whereas the interviewees stated that the economic crisis triggered the introduction of user fees, the fees could have been levied in various ways. For instance, the government could have introduced an insurance premium or a co-payment system rather than

resorting to a user fee system. Also, policy actors were not and must not be viewed as mere passive objects that simply responded to the dictates of the policy environment. To bring about policy change, political actors needed to seize the window of opportunity and express their agency, regardless of the external-contextual pressures they faced. For example, as indicated above, the decision to adopt, implement and sustain the user fees was also mediated by cognitive, ideational and rational factors that cannot be related to contextual influence in the strict sense of the word. Thus, actors used political strategies to shape the policy environment to either favour or oppose change and determine its outcome. Some of the strategies reformers used to bring about the user fee policy included policy drift, ideational framing and coercion. These strategies largely explain why user fees were not only adopted, but also implemented and sustained.

## **5.6. Conclusion**

In this chapter, I have examined how and why the user fee policy became successful, despite the ideological conflicts and vested interests, and the fact that similar efforts in the past had all failed. The analysis, as summarized in the table below, reveals how the perception of crisis pushed the PNDC to introduce far-reaching user fees despite all odds (ideological, political, and historical) and transform the health care trajectory in Ghana.



**Table 5 Summary of factors leading to the introduction of the user fee model**

<b>Factors</b>	<b>Specifics</b>	<b>Contributions</b>
<b>Conjunctures</b>	<ul style="list-style-type: none"> <li>• The 1980s economic crisis</li> <li>• Fiscal crisis of the health sector</li> <li>• The 1981 coup, resulting in the PNDC coming to power</li> <li>• Global trend towards small-government</li> </ul>	<ul style="list-style-type: none"> <li>• They created a window of opportunity, urgency or motivation for policy change rather than self-determined the change needed.</li> </ul>
<b>Policy entrepreneurs</b>	<ul style="list-style-type: none"> <li>• The GMA, MoH, PSoG, IMF and World Bank</li> <li>• The Rawlings government</li> <li>• The Adibo design team</li> <li>• The committee of secretaries</li> <li>• Service providers</li> <li>• New stakeholders the policy developed over time</li> </ul>	<ul style="list-style-type: none"> <li>• They seized the open window to establish the user fee policy across various stages of the policy process.</li> <li>• Different policy entrepreneurs playing different roles were identified across various stages of the policy process.</li> <li>• What made them unique and relevant for the changes were their leadership, strategies and commitment to the change.</li> </ul>
<b>Institutions</b>	<ul style="list-style-type: none"> <li>• Military political system, with no parliament</li> <li>• The transition to a democracy in 1992 where the government held majority of the seats in the party-disciplined parliament</li> </ul>	<ul style="list-style-type: none"> <li>• These concentrated institutions minimized veto points for interests to overturn the user fee policy.</li> <li>• They also made it less difficult for policy entrepreneurs to adopt the user fee policy.</li> </ul>

With regard to how the change occurred despite ongoing ideological conflicts, I argued that it was largely the result of the failure of earlier socialist measures to address the economic crisis, the consequent aggravation of the crisis itself, the PNDC's decision to introduce the SAERP and, most importantly, the policy entrepreneurship of principal stakeholders of the new policy. The failure of socialist policies and the gravity of the economic crisis created a climate of uncertainty where bearers of alternative policy ideas were able to shift the government's attention towards an ideologically polarizing policy like user fees. However, as indicated above, it required a significant level of political will and strategies to ensure its implementation and sustenance.

An increased number of vested interests opposed to the policy emerged even from within the PNDC, the army, labour and the general public. Yet they were overpowered by the reformers' high level of political commitment and effective strategies, including the PNDC government's willingness to use coercive force, to protect the policy. In fact, because of the ruthless nature of the strategies of the reformers, those opposed to the user fee policy kept a

low profile compared to earlier ones (1968, 1969, and 1981) that had failed (Arhinful, 2003; Apoya & Marriott, 2011; Coleman, 2011). This study contributes to actor-centred institutionalism by providing additional mechanisms – frames, legislative inaction or drift and coercion – to reinforce its capacity to explain path-departing policy change.

## **CHAPTER SIX**

### **THE INTRODUCTION OF SOCIAL HEALTH INSURANCE**

#### **6.1. Introduction**

In the early 2000s, another milestone in health policy change occurred in Ghana: the 2003 passage of the National Health Insurance Scheme (NHIS) Act (Act 650). Act 650 introduced social health insurance (SHI) and prepayment mechanisms into the health care financing and delivery processes and made it mandatory for every Ghanaian to belong to the policy. The National Health Insurance Authority (NHIA) was established as the principal body to implement the policy. With the goal of universal coverage in mind, the policy sought to abolish the pay-before-service principle underlying the existing user fee model for a universal health coverage through SHI. In this chapter, I will examine the process of transitioning from the user fee model to the NHIS of Ghana.

As with user fees, examining how the NHIS was introduced is critically important for understanding not only how path-departing health care change occurs, but also how it can occur within a context characterized by factors that should theoretically prevent such an outcome. For instance, when the NHIS was introduced, not only had Ghana not met, the underlying conditions to successfully introduce a SHI system, but also believed to be far from meeting them. (Shaw & Griffin, 1995; Ensor, 1997; Criel, 1998; Saleh et al, 2012). These conditions include a) a high population density, particularly in urban areas; b) a disproportionately high percentage of formal-sector workers and; c) a high per capita income and growth rate (Criel, 1998; Gertler, 1998; McIntyre, 2007). Ghana, on the other hand, had a high (87.1%) age dependency ratio and its economically active population hovered around just 43.8% (Ghana Statistical Service [GSS], 2005). With the rural population accounting for about 52.8% of the entire population in 2000, Ghana's population patterns were unripe for a SHI system (GSS, 2005). Ghana's informal sector was also much larger than the formal sector, accounting for

about 70-90% of the total workforce (Rosa & Sheil-Adlung, 2007). As for the economy, in 2001 and for the first time, Ghana was ranked as highly indebted and actually joined the Highly Indebted Poor Countries (HIPC) program, pleading for debt forgiveness. Also, as seen in Table 6, Ghana's economic situation does not compare with any of the four countries Gertler (1998) studied during the periods they introduced universal SHI systems.

**Table 6. Economic conditions when Universal Social Health Insurance was instituted in selected countries compared to Ghana**

Country	Real \$GDP per Capita	Real GDP Growth (1960-1992)	% Urban
*Japan (1961)	9, 290	-	-
*Korea (1989)	5, 371	10.49	66
*Singapore (1986)	8, 464	7.90	100
*Taiwan (1995)	9, 750	9.17	57
#Ghana (2003)	2, 238	1.8 (1990-2003)	45.4

Sources: \*Gertler (1998, p. 730)

# McIntyre (2007, p.56)

For example, while all the countries in Table 6 had per capita GDP of between \$5000 and \$10,000 at the time they introduced universal health insurance, Ghana's GDP per capita was just above \$2,200. Also, at the time they introduced their policies, all the other countries had a faster economic growth, averaging about 8% a year, compared to Ghana's growth rate of about 1.8%. Finally, Ghana's level of urbanization was significantly lower compared to these four countries.

Other potential challenges to the change included the rightist-orientation of the government (NPP) that introduced the policy. That should be problematic given that ideologically right regimes are generally believed to be biased against broad social programmes compared to their left leaning counterparts (Hick, 2011). This was confirmed through the interview process, as the minister in charge of the policy development process noted, "within my own party, within my party, they meant well, but they were very apprehensive" (Afriyie,

2013). Another former minister made a similar observation. He said, “I remember at that time, cabinet, my colleagues were saying why should I make it government, it should be private... give it to the private sector” (Anane, 2013). Especially baffling in this regard was the fact that the new policy was introduced against the wishes of powerful international actors, including the World Bank and the IMF, among others, who preferred to maintain the status-quo (Adusei, 2013). In fact, to a majority of the external actors, SHI was impossible in a developing country like Ghana due to its vast informal economic sector (Agyepong, 2013).

The above argument is not to suggest, however, that all opportunities for change were closed. Key domestic stakeholders seemed unanimous in their belief that the existing user fee model was unsustainable (Alfers, 2013). By 2003, public opinion was also strongly in favour of health insurance (Babooroh, 2013; Niitreb, 2013). Additionally, there had been an important transition from the NDC to the NPP, the two main political parties in the country. This change seemed conducive to new policies (Kingdon, 2003; Adams, 2013). Nevertheless, many of these opportunities were limited by a number of factors. Particularly, although there was strong public support for health insurance, the specific type of insurance was still in doubt (Seddoh, Adjei & Nazzar, 2011; Agyepong, 2013; Benya, 2013). As Benya (2013) put it, “you see a lot of political parties in their manifesto proposing to implement one form of insurance or the other even though the specifics were not given”. Nortey (2013) confirmed the same point and noted, “we were expecting a change but we didn’t know it will be this way”. Also, as indicated above, the government that emerged from the political transition in 2001 subscribed to an ideological orientation that should have made maintaining the status quo preferable to change (Afriyie, 2013; Akor, 2013; Anane, 2013). Based on much of the political economy literature that analyses the interactions between opportunities and threats in policy change, it could also be expected that the latter would prevail over the former, thus favouring the status quo (Pierson, 1996). In this way, even if it had miraculously made it on the policy agenda, the NHIS could

still have been expected to fail in the face of opposition. Yet not only was the NHIS introduced, it was implemented and has since been sustained, despite grave challenges (Andoh, 2013).

In the sections that follow, I will examine why and how the NHIS became law in the early 2000s and how it was implemented and sustained. However, as in the previous two chapters, this chapter begins by exploring the nature and magnitude of the change before accounting for why and how it occurred. It also stresses the utility of dynamic institutionalism, and particularly the combined heuristic power of Kingdon's (2003) window of opportunity framework and Grindle's (2004) dynamic political process model in explaining the advent of path-departing health care change in Ghana.

## **6.2. Examining the Nature and Magnitude of the Change**

### **6.2.1. Spending Change**

Alfers (2013) notes that, "the softening of neo-liberal policy during the 2000s has allowed for some improvements in the rather dire situation which the Ghanaian health system was in by the end of the 1990s" (p. 5). For example, there was a rise in both total and per capita health expenditure since the introduction of NHIS, from US\$ 547.6 million in 2006 to US\$ 1093.72 million in 2008<sup>40</sup> (Seddoh et al., 2011), and from US \$11.00 in 1999 to US \$21.66 in 2007, respectively (Global Social Trust, 2003; Ministry of Health, 2008). As well, public expenditure on health care increased, from 41.4% as a percentage of total health expenditure in 2000 to 59.5% in 2010 and 56.09% in 2011 (World Bank Indicators, 2015). Government expenditure as a share of the total budget on health care also experienced increases, from 8.0% in 2003 to a high of 16.2% in 2006 before falling back to 12.8% in 2009. (Gyapong et al., 2007; Seddoh et al., 2011). In a similar manner, general public expenditure on health care as a percentage of GDP increased from 2.4% in 2000 to 4.7% in 2005, before dwindling to about 3.0% between

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<sup>40</sup> These figures were converted from GH¢502 million to GH¢1,157 million, using average exchange rates of US\$ 1= GH¢0.916452 (2006) and GH¢1.057858 (2008), respectively.

2010 and 2012 (World Bank indicators, 2015). The MoH's share of the total budget increased from US\$522.29 million in 2006 to US\$ 602.79 million in 2007, US\$711.09 million in 2008, and US\$ 654.41 million<sup>41</sup> in 2009 (Seddoh et al., 2011). As Seddoh et al. (2011) note, the health sector received the third most funding in the 2006 budget, after economic affairs and education.

Much of the increased public expenditure on health care had also gone to support issues and areas that benefit the poor. For instance, in 2006, for the first time in over two decades, Greater Accra, the most urbanized and developed region in the country, received one of the lowest rates (4.7%) of government funding for the health sector, while the Central and the Upper West regions, two of the poorest regions, received much more (12.4% and 8.3%, respectively) (UNICEF, 2009). That trend, however, reversed afterwards (UNICEF, 2009).

In contrast to the rise in public health care expenditure, private expenditure on health care as a percentage of total health expenditure dropped from about 60% in the 1990s to about 40% in the early 2000s<sup>42</sup> (WHO, 2004). A similar thing occurred with respect to private health care expenditure as a percentage of GDP, dropping from 4.2% in 2000 to 2.1% in 2011 (World Bank Indicators, 2015). In addition, out-of-pocket expenditure declined significantly, from 47% of the total health expenditure in 2000 to 37% in 2009 (Saleh, 2013) and from about 80% of private expenditure in 2000 to 66% in 2010 (World Bank Indicators, 2015). In fact, out-of-pocket spending was halved between 2004 and 2007 (Saleh, 2013). The NHIS, which accounted for about 80% of the internally generated funds of the MoH facilities in 2009 (Schieber et al., 2012), surpassed user fees as the major source (80%) of revenue for public health care providers in the country (Nyonator, & Kutzin, 1999). In this respect, it can be argued that the NHIS has resulted in a significant change in the financing of health care in Ghana.

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<sup>41</sup> The original figures include GH¢ 478,654,800 in 2006, GH¢563,756,400 in 2007, GH¢752,233,368 in 2008, and GH¢ 921,929,472 in 2009. They were converted into US dollars using the following exchange rates: US\$1 = GH¢0.92 (2006); GH¢ 0.94 (2007); GH¢1.06 (2008) and GH¢1.41 (2009).

<sup>42</sup> However, Schieber et al. (2012) report a drop in private expenditure on health as a percentage of total health care expenditure, from 56% to 47% between 1995 and 2009.

### 6.2.1. Institutional Change

In addition to the changes to financing, there has also been a significant shift in the institutionalisation of health care since the introduction of the NHIS. For example, by 2010, about 66% of the population had registered with the policy, and 59.5% were card-bearing members (Kotoh, 2013). The cumulative membership size increased to about 70% of Ghana's population in 2011 (NHIA, 2011). However, due to a high rate of non-renewals, annual active membership of the NHIS has been significantly lower than the total membership, averaging only about 35% of the population in 2012 (NHIA, 2012).

In terms of service provision, the introduction of NHIS has led to a shift from limited benefit coverage of only public health related issues such as immunization and treatment for tuberculosis to a much more comprehensive benefit coverage, covering about 95% of all diseases and health conditions in Ghana (Osei<sup>43</sup>, 2013). As Table 1 illustrates, among other things, NHIS covers the costs of drugs, inpatient care, both specialist and general outpatient care, eye care, and dental care. It excludes only the most expensive, specialized services such as brain and heart surgery other than those resulting from accidents and organ transplant, among a few other things (Saleh, 2012; Kotoh, 2013).

The basic institutions for health service delivery have also transitioned, with the creation of additional bodies such as the National Health Insurance Council (NHIC) and the NHIA, complementing existing institutions like the MoH, the GHS and religious and other private actors. In this new structure, the MOH serves as the main agency for policymaking for the health sector, whereas the GHS and the private-based actors serve as providers and must be accredited before they are allowed to operate under the NHIS. Figure 3, below, shows that

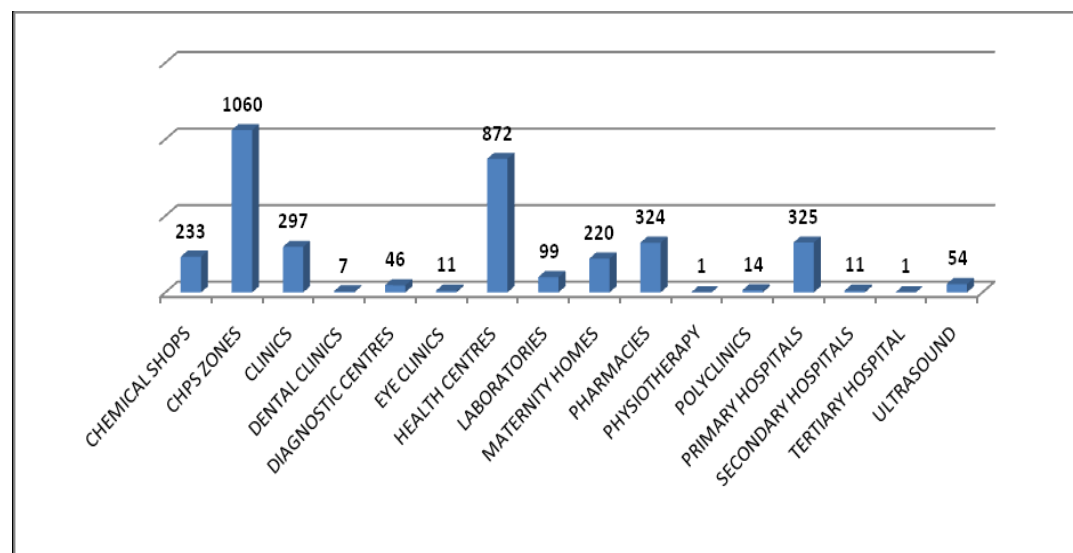
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<sup>43</sup> Osei was an officer of the Planning and Monitoring Unit of the Ghana Health Service. He was involved in the preparatory work on the NHIS by determining its financial implications on the health sector.



about 3575 provider facilities, including hospitals, clinics, pharmacy shops and laboratories, among others, had been accredited to operate under the NHIS by 2012.

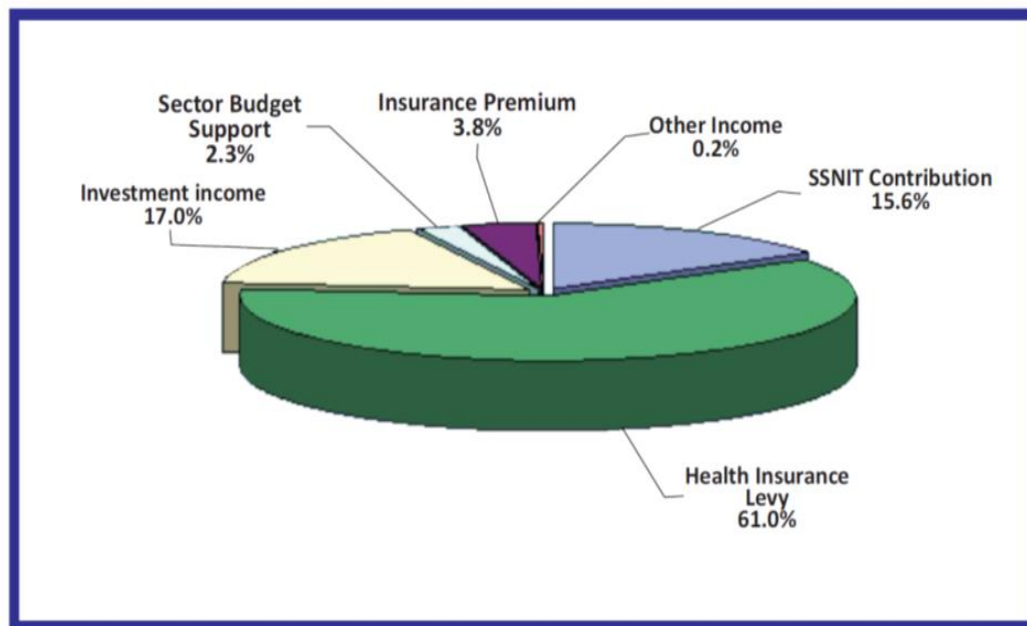
**Figure 3 Number of accredited providers under the NHIS as of 31/12/2012**



Source: NHIA (2012, p. 29)

The NHIC basically serves as the governing board for the NHIA. In place of direct cash payment at the point of service, a National Health Insurance Fund (NHIF) has also been established. The NHIF entails a 2.5% National Health Insurance Levy (NHIL) charged on certain goods and services, 2.5% deduction from the 17.5% social security contribution (SSNIT) of formal sector workers, annual budgetary allocations to the scheme, returns from investments by the scheme, grants and donations from philanthropists, as well as annual premium of between GH¢7.20 to GH¢ 48.00 from members of the informal sector, depending on their economic standing. As seen in Figure 4, at the end of 2009, the NHIL formed the majority (61%) share of the total revenue of the NHIS, followed by investment income (17%) and formal sector workers contributions (15.6%) to the Social Security and National Insurance Trust (SSNIT) fund.

**Figure 4 Inflow to the NHIS as of 31/12/2009**



Source: NHIA (2009, p. 34)

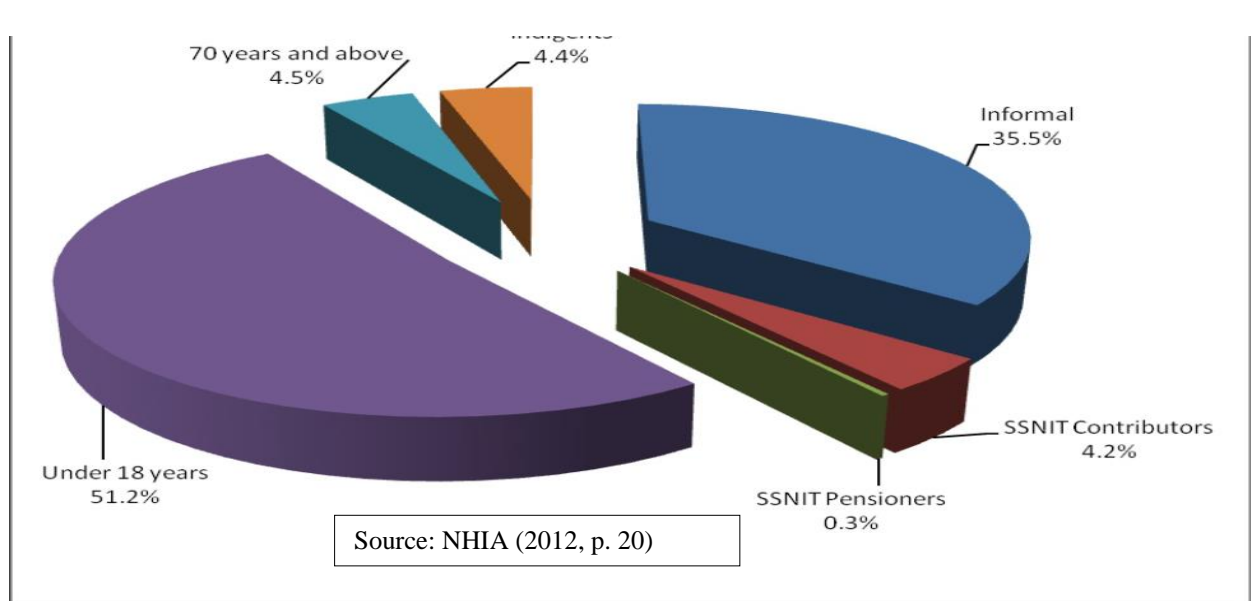
There has also been a significant change in access to and utilization of health care since the advent of the NHIS (Mensah, Oppong & Schmidt, 2009). For example, whereas only 626,765 people used Ghana's health care system in 2005, the number had shot up by about 2,708% by 2009 (Akum, 2014). Both inpatient and outpatient utilization also doubled between 2005 and 2007 (Ministry of Health, 2008 cited in Kotoh, 2013), much of which is attributable to the relatively generous premium and benefit coverage under the policy.

As seen in Figure 5 below, the policy also has a broad exemption category. It encompasses children, aged, indigents, and SSNIT pensioners (Appiah, 2012). If SSNIT contributors<sup>44</sup> are added, total exemptions account for over 60% of the members of the NHIS.

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<sup>44</sup> SSNIT contributors are generally formal sector workers. Although they contribute towards financing the NHIS, the law includes them under the exemption category because they were able to strike a deal with the government during the reform process to use their contributions as a loan, which is only to be returned with a gratuity from the government in case their pension fund runs bankrupt. However, it became clear in the interviews that, because no formal documents related to this decision were signed between labour and government, leaders from both sides appear to have conflicting interpretations on the matter.

**Figure 5 Composition of Membership of the NHIS as of 2012**



Despite these changes, there are some areas of continuity in contemporary Ghanaian health care policy. For instance, as can be inferred from Figure 4, revenue from taxes (NHIL and budgetary support) funds 63.3% of the NHIS. The number of health facilities under the NHIS has also remained relatively constant, perpetuating the problem of urban bias in health service delivery. Also, while a significant number of marginalized people have enrolled in the health insurance system, much of the lowest-income population are reportedly still without insurance due to a number of reasons, including the lack of capacity in identifying who is really poor (Apoya & Marriott, 2011; Osei, 2013). Despite the above points of continuity, the changes witnessed since the introduction of the NHIS have been significant. Importantly, consumer satisfaction with the health service delivery system has greatly improved across all income groups from 57% in 1997 (Ghana Statistical Service [GSS], 1997) to about 90% in post-2003, when the NHIS was introduced (NDPC, 2009; Turkson, 2009; Twum, Selotlegeng & Cheng, 2015). For example, 94% of selected the patients in facilities in the Komenda-Edina Eguafo-Abrem District were satisfied with the health system and willing to recommend it to colleagues (Turkson, 2009). In the section that follow s, a critical examination of the policy change process, showing how and why the transition to NHIS occurred, is provided.

### **6.3. Why and How the Change Occurred**

#### **6.3.1. Problem Definition and Agenda Setting**

Although the legislation was passed in 2003, NHIS first appeared on the policy agenda under the Progress Party (PP) government in the 1970s (Adjei, 2013; Afriyie, 2013). However, it was not given as much attention as the user fee model, resulting in its disappearance from the agenda until the 1980s and then again in the early 2000s. Moreover, the government was overthrown by the 1972 coup, leading to its inability to pursue the policy any further (Andoh, 2013). In the early 1980s, the GMA invited the People's National Party (PNP) government to explain its manifesto on health care to its members for an informed discussion. During that discussion, the representative of the government also spoke highly of NHIS, but he concluded that although it was a more appropriate policy, NHIS was unfeasible in a developing country like Ghana, where a large informal sector would make premium collection impossible (Adibo, 2013). This, of course, was in line with the popular notion at the time. In the end, user fees, rather than the NHIS, were implemented.

The challenges created by implementation of the user fee model, some of which have already been highlighted in the preceding chapter, were generally highlighted by the interviewees as having triggered the shift towards NHIS in the 2000s. As Awithey (2013) noted, “with the cash-and-carry, now you have the drugs there, now you have anaesthetic drugs available, but the people’s ability to pay, to access health care was making it inaccessible for them”. The situation was even graver for people in rural areas who were already facing geographical access problems. As Akosa (2013) stressed, “the nearest hospital was greater than 10 miles... [and] finding a vehicle ... to get to the hospital itself was a big problem” (Akosa, 2013). Under such conditions, the sick would likely suffer greatly during emergency situations.

As Anane<sup>45</sup> (2013) noted with respect to a woman who had come to his hospital to deliver her eighth child,

Normally, they will be confident that they can deliver, [but] this woman couldn't deliver. Her womb was ruptured, the baby was extruded into the abdomen. They were at home, according to her, she was in labour for more than two weeks....all her eyes were even yellow, she was dying, that's how the family met and found some money, carried this woman from over 20 miles in the cocoa area...they arrived at Komfo Anokye [hospital] at 1 am. This woman was going to die. The fortunate thing was that at that time my friends in the US had sent me some drug samples very powerful drug. It was the drug we used for the woman. She is still alive, but here was a woman who because of lack of money had ruptured her uterus, the baby had gotten rotten in her abdomen, she had gotten septic and was on the verge of dying.

The above passage illustrates the ordeal many vulnerable people faced during the user fee regime because of their inability to pay for medical care. In fact, many of the people who found themselves in the above situation reportedly died, making the user fee policy one of the most dreadful policies in the country at the time (Nortey, 2013).

The user fee policy resulted in a drastic reduction in attendance and utilization of medical care. As Adjei (2013) noted, “attendance by a person was once in three years instead of once in a year. And it was basically because they said they didn't have money”. The drop in utilization was particularly greater for outpatient services compared to inpatient services because most patients waited until their sicknesses worsened before seeking medical care (Akanzige, 2013). The situation was “worst among the poorest”, a situation that significantly widened “the equity problem” with respect to access to health care in the country (Agyepong, 2013).

There was significant public dissatisfaction with and agitation against the user fee policy. As Adjei<sup>46</sup> (2013) stated, the press continually blamed the government for introducing “hospital fees system at the instigation of the World Bank to the detriment [of the public] and, so something should be done about it”. The issue that attracted overwhelming media attention

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<sup>45</sup> Anane was the first minister of health during the Kufour Administration. He initiated the design of the NHIS. However, he was soon removed from that post due to a cabinet reshuffle by the President.

<sup>46</sup> At this time, Adjei was serving as a member of the design team of the NHIS.

involved the practice of detaining nursing mothers in health care facilities because they could not pay for their deliveries. As Akor<sup>47</sup> (2013) indicated, the media consistently revealed numerous patients that were “detained because they couldn’t pay”. In addition to being detained, the majority of the mothers had to endure horrible conditions such as “bare floors, congestions [overcrowding] and so forth, which were creating problems”. The role of the media in spreading this news was facilitated by the democratic process that Ghana entered into in the 1990s. The process resulted in an upsurge in media stations, which contributed in popularising the challenges of the user fee policy. Seddoh<sup>48</sup> (2013) declared,

Between 1998 and 2000 ...there was a huge increase in private media, especially, in the local languages. If you remember the famous fight between Peace FM and Radio Peace at that time, that was when news radio was coming on board. And they were all in the local language. So the education on the issues were picked up in local languages, which the people could easily engage with. So it was easy for them [ordinary people] to pick a phone and call into a radio station and talk about the real issues facing them in the languages that they could express themselves. So that became a big issue, and health care was always in the media at the time.

Besides the media, the situation attracted the attention of government officials and parliamentarians, most of whom “were [already] at the receiving end where within their constituencies people were always coming and asking for money and other things” (Seddoh, 2013). Another effect of the democratic process was that it introduced an electoral system, which offered additional windows of opportunity for change. For instance, as Seddoh (2013) argued,

From 1998 to 2000 was an election period. In fact, it was a heavy electioneering period. We had the elections at that time, and every politician... in fact, all [of them] were very quick to pick up on what the people too were picking up on. And for any politician, popular opinion is the voice of God. So as health became the main issue, it was easier for them [the politicians] to bash at each other on health care.

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<sup>47</sup> Akor was the chairman of the design team of the NHIS.

<sup>48</sup> Seddoh was also a member of the design team of the NHIS.

Elected officials, therefore, began to discuss the user fee policy's impacts in parliament. Adjei (2013), for instance, recounted the extent to which the user fee problem was debated in parliament during the 1990s:

I still remember one of the editors of the newspapers, who was called Mr. Jewu Chem. He had been elected as a member of parliament, and so he was very strongly against it [the user fee policy]. He tabled the whole issue in parliament. He tabled it because some students from the University of Ghana were involved in an accident. They were travelling on a bus and got an incident. When they were taken to the Police Hospital for treatment, the Police Hospital said if you don't have money to pay [for the treatment, then] it won't see them [the students]. So the university students [in Accra] got very angry and they went on street demonstration ... So Mr. Jewu Chem took it up and tabled it in parliament. And there was a lot of discussion and debate on the issue.

Thus, by the 1990s and early 2000s, the adverse effects of the user fee policy were well known. In fact, according to Seddoh (2013), "you didn't need literature to tell you that [the user fee was problematic], the obvious thing was there and it was showing that the indicator, per capita utilization of health services, which is simply the number of times somebody uses ... [or is] likely to use health services were low".

In view of this predicament, as Adjei (2013) noted, "a whole [political] movement about abolishing cash and carry then started". In response, the politicians began to consult health care experts in the MoH for solutions (Agyepong, 2013; Seddoh, 2013). Although it had begun earlier under the PNDC's military regime, these consultations became a common phenomenon after the transition to democracy in 1992 (Agyepong, 2013; Akanzige, 2013; Seddoh, 2013). In the process, NHIS was once again pushed onto the agenda of government officials and members of the opposition political parties alike (Agyepong, 2013; Seddoh, 2013). During the interview, Agyepong (2013) explained how NHIS became the focus of so much attention:

Ghana had already come from British style to provide free tax funded after independence and we found we were not generating enough taxes, our economy couldn't support it... And then we tried out-of-pocket fees and we also found...there were huge equity problems... So if you have already come down a particular road, looking for a solution, you don't go back that road. So people were kind of saying how else do people fund health care?

In this respect, NHIS was seen as the only alternative left for dealing with the access problem in the health sector. This perception may have been fuelled by the predominance of local thrift associations or practices as “*susu*<sup>49</sup>” and “*nnoboa*<sup>50</sup>”, which embodied social insurance related elements such as energy and revenue pooling to support members during times of need. Andoh<sup>51</sup> (2013) confirmed the impact of these local systems on the transition to NHIS during the interviews. He noted, “the concept of solidarity has always been there, and we find it in the villages [more] than in the cities. People die in the village, attend funerals and give money to the people just to make sure they don’t suffer”. Mensah<sup>52</sup> (2013) made a similar comment, declaring that,

If you look at even when insurance started, the local communicates did well, the rural areas... Because in the local areas, you have that *nnoboa*, that solidary concept where your brother’s concern is yours, you know the next person living next door so that thing helped.

Another important factor was the widespread existence of the Community-based Health Insurance Schemes (CBHIS) in the country at the time (Adusei<sup>53</sup>, 2013; Akor, 2013). Led by the Catholic Church, CBHIS began to spring up across the country in the face of the government’s failure to address the health care accessibility problem and the rising phenomenon of default payments in many provider facilities across the country. Whereas only one CBHIS was established by the Catholic Church in Nkoranza in 1992 (Akor, 2013; Mensah, 2013; Sorsy, 2013), “about 159 [of such] schemes had been established as at 2001” when the NPP government began the process of “moving to health insurance and they were in about 60

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<sup>49</sup> *Susu* is a micro-saving scheme in communities in Ghana. Usually a trusted member of the community establishes it and ask other members to contribute any amount they could it. The owner comes round daily or weekly to collect the contributions. At the end of the month, members are allowed to withdraw their total savings. However, they lose one of their contributions to the scheme owner for his/her service.

<sup>50</sup> *Nnoboa* is an informal agreement among farmers in Ghana to help each other during times of needs such as land cultivation and harvest. It involves sacrificing time and money to help each other during times of need.

<sup>51</sup> Andoh was a key member of the NHIS design process and a secretary to the Minister of Health (Dr. Afriyie). He also spearheaded the policy’s implementation in some districts in the Western Region of Ghana.

<sup>52</sup> Mensah was involved in the coordination of the role of the Christian Health Association of Ghana in the journey towards introducing health insurance in Ghana and the implementation the NHIS.

<sup>53</sup> Adusei was also a member of the NHIS design process, serving as a representative of the Ministry of Health and secretary to the chairman of the design team.



districts across the country” (Andoh, 2013). They were, however, limited by the fact that most of them focused only on hospitalization and their numbers were small (1% of the population) (Adjei, 2013; Amoh, 2013; Mensah, 2013). Nevertheless, as Mensah (2013) noted, these CBHIS “played a role in terms of advocacy and pushing the policy [NHIS] agenda”. For instance, they utilized the annual stakeholder meetings in the health sector as opportunities to make presentations on the positive effects of their policy ideas (Akanzige, 2013). Hence, as Akor (2103) argued, these CBHISes created the impression among government officials that “it [health insurance] is doable, it’s feasible”.

Key policy entrepreneurs in the MoH also made a conscious effort to push NHIS high onto the agenda of government officials and political parties, as Seddoh (2013) noted during the interviews.

We invited government officials and political parties to the Health Partners’ summit. Some of the participants were members of parliament. Some of them were also on the parliamentary select committee on health. We kept inviting these actors to the Health Partners’ summit which was held twice a year to discuss these [health care] issues and possible solutions to them. And so we started to convince them about the ease with which we could do social insurance...that should be able to take away the problem we were having with health financing. So with that [the help of the summit] we could build popular allies.

The implication of the above is that the design team managed to frame the policy idea to convince core policymaking bodies in the health sector.

In addition to the above, as Seddoh (2013) emphasized, “we used the media. Used scientific articles. Because they go to the world health assemblies, we tried to get those issues adopted in resolutions. At the World Health Assembly ... In 2000 and the late 90s, they debated the issues [of the health sector] heavily”. Some of the scientific articles the interviewees frequently cited that helped them push their ideas forward involved studies on health care financing by scholars such as Nketia Amponsah, Nyonator and Kudzin, Asenso Okyere, Chris Atim, and Professor Lambo (Adjei, 2013; Akor, 2013; Seddoh, 2013; Sorse, 2013). Hence, beyond the rhetoric to abolish the user fee policy during the 2000 elections, Benya (2013)

noted, “you see a lot of political parties in their manifestoes [also] proposing to implement one form of insurance or the other”. Afriyie<sup>54</sup> (2013) confirmed this and also argued, “the whole [political] atmosphere was very expectant” of health insurance. One of the key political parties that proposed introducing NHIS during the election was the NPP, which was then in opposition. Speaking about the role of the opposition party in keeping the NHIS on the agenda, Andoh (2013) revealed,

The then government which was in opposition managed to convince the population that if they were voted into power they were going to leave them with the Health Insurance Scheme and fortunately they won the power. And for me, it was like a social contract with the people and they had no basis to default that promise, so eventually when they came to power, of course, the first thing was for policy development and legislating all these structures, building up the structures that will drive them to the implementation process and so eventually in 2003 the law was passed.

The 2000 elections that Andoh (2013) describes above were a crucial moment in the transition to NHIS because it brought in a new government that was bent on introducing NHIS, no matter the odds (Agyepong, 2013; Sorse, 2013). For instance, responding to the question as to the number one factor that made the NHIS successful, Seddoh (2013) emphasized political will. He said, “It is the political will of the government to do it irrespective of what anybody thinks”. Almost all those interviewed for this study emphasized the NPP’s commitment to introducing the policy. This commitment can also be seen in how the NPP shaped the policy process after winning the election. In particular, “the president, on appointing his ministers, decided to make health insurance one of his performance indicators for that minister” (Seddoh, 2013). This was confirmed by the Minister of Health at the time, who highlighted that his “main agenda was to spearhead the introduction of the health insurance scheme” (Afriyie, 2013). Beyond helping to push NHIS high on the agenda, the election helped to shift public discussion from “private health insurance to government ownership...or social health insurance”

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<sup>54</sup> Afriyie was the minister of health after Anane. He spearheaded the development and implementation of the NHIS.

(Benya<sup>55</sup>, 2013). Thus, besides the user fee crisis and the policy entrepreneurship provided by the CBHISes and the MoH, the 2001 election was also crucial in the introduction of the NHIS to the political agenda. Explaining the agenda setting process, therefore, requires looking at both the conjunctural factors that created the window of opportunity for change and the policy entrepreneurs that seized the moment to propel the policy idea onto the governmental agenda.

### **6.3.2. Policy Formulation/Design**

The Minister of Health put together a seven-member design team with a mandate of helping the MoH develop an NHIS framework, including determining the basic benefit package and financial modalities for running the scheme (Agyepong, 2013). Unlike that of the user fee model, the membership of this design team was broadened to include experts outside the public sector. However, the members were united by the fact that they had some expertise or experience in health insurance, either as current operators or as facilitators of a similar process in the past (Agyepong, 2013). The members were drawn from the MoH, the GHS, the TUC, the Ghana Healthcare Company, and the Dangme West Mutual Health Insurance and Research Centre. With such diversity and since the various stakeholders were expected to bring their own perspectives to the process, it was expected that the team would come up with a more representative policy (Akor, 2013). Unfortunately, each party promoted its own interests, leading to inability of the team to progress. As Seddoh (2013) noted, “the academics [on the team] wanted the academic way and so they were like, we haven’t finished exhausting the academic debate. And we need to write more papers”; whereas others on the team thought that “there was already substantial research - the fact that it was not published in scientific journals

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<sup>55</sup> Benya was part of the team that was put together to explore the development of the NHIS before the 2000 election, which resulted in a change in power from the NDC to the NPP.

did not mean that the evidence was not there”. Alternatively, as Akor (2013) argued, “there was a lot of disagreement among the committee and this led to its disintegration”.

In addition to procedural conflict, there was disagreement over “the form of health insurance” (Akor, 2013). For instance, the chairman and most members of the design team preferred a CBHIS, while the minister and a few others wanted a centralized system (Anane, 2013). My investigation into the matter revealed two main interesting but contrasting ideas. Those supporting the centralized approach had the intention of preventing corruption that could result from leaving the process entirely in the hands of communities. As Anane (2013) commented,

My feeling was that if we permitted the mutual [CBHISes] schemes to pass, at that time there were about 118 districts and we would have 118 mutual schemes. To me it also meant that we would have 118 management centers with a very big overhead cost. Apart from that, we would have 118 centers of corruption...I knew that we didn't have enough personnel who had knowledge about this national health insurance schemes so if you were making 118 district schemes, who were going to manage it?

On the contrary, those who were rooting for the CBHIS approach were claiming that the centralized approach did not work. As Agyepong (2013) notes,

the NDC [past government] was also searching ... Their approach had been to set up a health insurance unit in MOH, i.e. a centralized approach. That [approach] didn't work because some of these things, this is my personal approach, I think sometimes, if you are too heavy at the centre with initiatives that have a lot of downstream, you may not succeed ... There were all those experiences that a centralized social health insurance system was ... probably not going to work for us. When the one by MOH collapsed ... the government tried it also with SSNIT ... The government put money into SSNIT and failed. So even the NDC government had been exploring insurance; it's just that the root they took didn't work.

The above quotes suggest that the design team was in disarray. According to Seddoh (2013), this ultimately led to “total paralysis”. However, because the majority of the members were in favour of a community-based approach, in the end, the team recommended that rather than getting actively involved, the government should just encourage various groups to establish their own CBHISes (Anane, 2013).

While this recommendation seemed technically sound and evidenced-based (Agyepong, 2013), it was rejected by the minister, who was more interested in a radical policy change (Anane, 2013; Amoh, 2013; Seddoh, 2013). Thus, soon after, there was a cabinet reshuffle and the minister was changed (Anane, 2013). The new minister set a time frame within which he wanted the entire policy design to be completed and taken to cabinet, as well as a time frame for when public input may be required (Afriyie, 2013). He anticipated that the policy's overall implementation date would be before 2004, when the government would be seeking a re-election. Hence, the minister reconstituted and transformed the design team, most notably by replacing the chair and bringing new members who favoured path-departing policy change. As the new minister noted, when he was asked to explain the criteria he used to reorganize the design team, "if you are not with me policy wise, if you think that we should set up a vertical system, [which would take] two or three years to set up, I had no time. So I kicked them out nicely to only constitute some committees, calling in some new people" (Afriyie, 2013). Explaining the circumstances surrounding his appointment, the new chair of the design team stated, "there was a lot of disagreement among the committee so ...I was brought in to reorganise them, that is what happened and I took over and led the process" (Akor, 2013). Agyepong and Adjei (2008) also note that the members of the design team who suggested anything contrary to the government's wishes were tagged or labelled as anti-government or as siding with the opposition to sabotage the government's work. Consequently, some of the early team members who were dissatisfied with the new developments also left the design team on their own. They were replaced by new members believed to be political associates of the regime and thus favourable to reform (Agyepong & Adjei, 2008). By the time the final decision on the policy was made, only a single original member remained on the design team (Agyepong & Adjei, 2008; Kotoh, 2013).

The Health Minister described the design team's final plan as

A federation of district health insurance schemes supported by the centre, that is government, but largely autonomous in their own self, having their own boards and their own directors and then dispensing claims and what not according to a minimum national criteria that they have to fulfil...We drew up a minimum national package, you could go above the minimum package but not below it...even two or three political districts which were contiguous could form a mutual health insurance district (Afriyie, 2013).

This new system was not entirely centralized, as the government had originally intended. That decision may have been influenced by the fact that some members of the new design team, including the new minister, did not support a wholesale centralization of the NHIS process. For example, as the minister stressed, “if you do a centralized thing and you don’t succeed, then the whole part falls down” (Afriyie, 2013). Hence, blending the centralization agenda with some levels of decentralization was seen as critical for sustaining the policy over time.

The overall implication of the above is that the reorganization project helped reformers overcome the forces within the design team who were militating against the path-departing health care change the government advocated. An LI to support the NHIS implementation was also designed afterwards through a similar process. Key aspects of the design included a provision for establishing three types of health insurance schemes: District Mutual Health Insurance Schemes (DMHISs) for the various local government units in the country, Private Mutual Health Insurance Schemes (PMHISs) for the not-for-profit sector and Private Commercial Health Insurance Scheme (PCHIS) for the private-for-profit sector. These major schemes were to be regulated by the NHIA. The final plan also included a multi-sourced National Health Insurance Fund (NHIF), whose components are explained above.

A number of factors underlay the successful work of the reorganized design team. The first factor involved the compatibility of team members. In particular, the reorganization resulted in a team that was cohesive, as a majority of them knew with each other prior to joining the team. As Seddoh (2013) revealed, “we were friends, we were actually friends, those of us who were in the middle were already friends not because of insurance, but because we served common interest so we became like team champions in the sector”. The second factor relates

to the fact that most of the members had no obvious stake in the status quo, as they were never part of any former or existing process of establishing a health insurance system in the country. Hence, they were interested in pursuing the change despite the odds (Agyepong, 2013).

The third factor is that the reorganized design team shared their ideas and brought on board multiple stakeholders, including detractors, enabling them to both consolidate and legitimate their choices. As Andoh (2013) noted,

We needed to have engagement with stakeholders to discuss the issues, so there were series of stakeholder engagements, involving civil society organizations, key stakeholders in the health sector like the Ghana Health Service, the Ministry of Health, the Christian Health Association of Ghana. The engagements were necessary because of the contribution component of the scheme, which was going to take the form of payroll deductions. So we needed to consult the Employers Association and the Trade Union Congress and then the private insurance schemes. There were a few private insurance schemes in the system and we needed to engage them in order to let them know that despite the National Health Insurance Scheme, their market will still remain as it is. Besides, Mutual Health Insurance Organizations were also in the system. In fact, about 159 schemes had been established as at 2001 when we were preparing to move to health insurance and they were in about 60 districts across the country. So they also had to come in and, of course, the Ministry of Local Government and rural Development had to come in a well.

Akor (2013) made a similar point. He said, “we had to go to the public so many times to make presentations. We had to do four zonal presentations. We brought all of them [civil society organisations] to these meetings, involving the four zones and one national ...to listen to the people’s view”. Representatives of civil society organizations like the PSoG confirmed that these meetings had taken place. As Awithey<sup>56</sup> (2013) noted, “we as stakeholders contributed our quota in helping to shape the policy. As major stakeholders who understand the dynamics of the procurement and supply of medicines and, therefore, we were very much involved so that ... we didn’t come out with a policy that was at variance with the law regarding supply of medicines”.

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<sup>56</sup> Awithey is the president of the Pharmaceutical Society of Ghana (PSoG).

In convincing apathetic stakeholders to embrace its design, the design team employed ideational frames. Amoh<sup>57</sup> (2013) recounted his role during the stakeholder consultation process.

I went to the Teachers Hall and they were bashing the health insurance, particularly, the 2½% contribution by workers. They were trying to convince SSNIT contributors not agree... But they didn't realize that I was there. So I got up and explained to the SSNIT contributors that the health insurance was good for them because it would save them disposable income. At least, their health care delivery expense would be out of their household budget. We went for lunch ...As soon as we returned and I sat down, about ten people came and threw me out of the room, teachers Hall. But it was too late; I had already convinced them”.

The fourth factor is that the design team read broadly, reviewing various models of health insurance across the globe. Describing the team, Akanzige (2013), for instance, noted, “this was more of a working group, practically sitting down, writing, looking at our situation, doing literature review of what has happened elsewhere”. They buttressed those reviews with frequent travels around the world to directly observe how the various models they had read about operated. For example as Seddoh (2013) affirmed, “we looked at the German system which had a similarity to a certain extent on what is happening and then we also look at Chile which had a certain example of a similar system and then we looked at Thailand”. The minister also travelled to the UK, Germany and Zimbabwe (Afriyie, 2013). Responding to why they undertook all those studies and whether they actually shaped the final decision of the team, the former minister responded,

To get the historical perspectives and the evolution of health insurance. The history behind it from Otto Von Bismarck to now in Germany is very instructive... It helped to the extent that it made me feel confident... it made me feel that this thing has been done somewhere before and if I noticed and took account of our peculiar situation especially, our weaknesses, then it made me feel confident that we could do it. Not that we said that we were going to copy somebody's things (Afriyie, 2013).

Adjei (2013) made a similar argument. He noted, “at least we could tell people when they ask us why we did it. We could tell them, we have been here, we have been there and we decided

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<sup>57</sup> Amoh is a system designer and the main consultant during the design and implementation of the NHIS.



to design our own”. Adjei (2013) added that, “...at least the England and the Germany ones helped in developing the concept of the hybrid [tax and contribution-based] system that we are using”. Seddoh (2013) agreed to the above assertion. He argued:

Based on these countries we decided to basically just scale up our system ... The only unique thing about ours is the tax system which is not so unique because even the German system is based on the tax system, but ours simply had the VAT system so we introduced that component to it and then we used some innovative financing like the social security and national insurance trust (SSNIT), which is not any different from taking payroll tax.

The implication of the above is that although they borrowed some foreign ideas, the design team did not do a wholesale importation of those ideas. Rather, they adapted them to suit the Ghanaian context. When I asked him about why they did not do a wholesale importation of the models they studied, the minister said,

Comparatively no jurisdiction at that time had the informal sector in the heart of this kind of social intervention ... if the economy of Thailand is such that (maybe) the formal sector is over 60%, then you may want to use it [a wholesale importation], but in our situation, it was a no (Afriyie, 2013).

The above quote confirms earlier arguments that Ghana’s large informal sector should have made it impossible for a health insurance policy to work, the conventional wisdom being that the formal sector must be larger than the informal sector for such a policy to be successful. Ignoring conventional wisdom and designing a health insurance system that reflected the unique situation of Ghana, the minister noted, “we focused mostly on the informal sector and as it were the formal sector was an added on ... In other words, we were not too aggressive about teachers joining, we were not too aggressive about miners joining but we were very aggressive about market women [joining] and we had targeted farmers, etc.” This process of adapting foreign models to suit domestic context is what Campbell (2004) refers to as translation, and Rose (1991) as lesson drawing. However, responding to the concern as to why they did not import Thailand’s model given its contextual proximity with Ghana, Adjei (2013) noted, “that one wasn’t a high level delegation, it was some [delegation] from the health service - it wasn’t like the minister. Even though some MPs also went there later on, it wasn’t a high

level delegation”. This suggests that beyond contextual influences, the calibre of the delegation involved in the lesson drawing process also shaped the lessons that were ultimately drawn.

Although it seemed to be quite technical, much of the lesson drawing process had political undertones, involving conscious attempts to avoid opposition from key vested interests. For instance, in response to why the team deducted the workers’ contributions to the NHIS from their pension (SSNIT) fund instead of their payroll, as observed in the social insurance nations they visited, Amoh (2013) noted, “we didn’t want to stress them up”. In the passage below, Seddoh (2013) makes the above argument clearer, noting,

It was uncomfortable asking workers to pay directly from their payrolls. Already labour agitations in the country around that time was bad. If you recall, there was a lot of labour agitations round 2000. In 1999, 2000, 2001. In 2001 alone doctors were on strike for about 49 days, teachers were also on strike. All these strikes were related to pay, so going to take anything off their pay slip would be a problem. Therefore, the thinking was that if they were already contributing to another pot of money [i.e. SSNIT] which were being invested, then why not invest part of such money in their health?

Deducting workers’ contributions from their pension fund was seen as a convenient solution because pension pays were based on the workers’ “best three years” of pay in active service rather than on the amount of money they had accumulated in their pension funds (Kuntulo, 2013). A similar strategy was employed with respect to how the informal workers’ contributions were calculated. Afriyie (2013) commented, “our research showed that majority of our farmers ...could afford more than that [the official amount], two times in certain areas, even three times what we were collecting then, but we decided to set the bar low so that people would enrol”. The design team rejected suggestions to introduce co-payment so as to reduce the potential of moral hazard on similar grounds, as Afriyie (2013) emphasized in the following passage:

Somewhere along the line, the concept of co-payment came up. But given that we were evolving from a cash-and-carry system, any semblance of the patient paying something, even a little token, at the beginning would have been pounced on politically by our opponents. Besides, our illiterate population would not have been able to differentiate the co-payment arrangement from the cash-and-carry., So we decided to postpone it.

The design team was also successful because they accommodated the interests of the existing community and private-based health insurance schemes, which had a significant following across the country, including donors (Akor, 2013). To avoid resistance from such great constituencies, as Agyepong (2013) noted, we “said we will have private mutuals [CBHIS and PCHIS] and public mutuals [DHMHISs]”. The minister agreed.

I didn’t want to exclude my private sector people, so we set the parameters. You can compete out there. That means a private mutual health organization should get some space to operate and also private for profit. It was for the purpose of providing a comprehensive service or the minimum services that we set the private schemes in competition with the government-based district mutuals. They also served as an added incentive. For example, prescription glasses were not on our original list, but I noticed that some private mutual health organizations allowed prescription glasses especially among school children. And so those were some of the things that happened. They have their clients now and they are growing, so am very happy. It’s also because of my ideological outlook. In fact, if I had my way, I would have shrunk those mutual health organizations. But, I saw this as a historical thing (Afriyie, 2013).

The minister’s response, however, suggests that there was also an ideological twist to the design team’s strategy of accommodation. This was also confirmed by another member of the design team in the passage below.

The government in power was the one that talks about private sector, private sector. So why do you build a social health insurance scheme that would collapse the private sector? Hence, we made it optional...Before the NHIS, there were other companies that were running private insurance schemes. They should remain. They should continue to run their private insurance (Andoh, 2013).

Thus, the strategy of accommodating private participation was also meant to deflate resistance from people on the far right, most of whom were believed to belong to the political party in power. However, in order not to reveal this, this strategy was sold to the public as not wanting “to collapse the existing mutual [CBHISes] ...Rather, they were introducing a basic [scheme] for everybody, but if somebody didn’t like that one or wanted an additional package, then he can have it. That was why three types of schemes were introduced” (Tony<sup>58</sup>, 2013).

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<sup>58</sup> Tony was a representative of the Ministry of Finance on the development of the NHIS. He was a member of the delegation that travelled across the country to solicit ideas from the grassroots to enrich the NHIS.

In order to accomplish their goal within the stipulated timeframe, the team also neglected technical details and a rational approach to decision making, which sometimes extend the process of policy change. As Seddoh (2013) indicated,

The public servant has a traditional way of doing things. Through evidence, you build consensus, you get all the technical opinions, then you submit it to another technical opinion and then the committee has to agree. That is how we used to do policy...However, it was not predetermined that things should go that way, especially when you have a lot of technical people on board. When the issue is of public interest and it has gained its own momentum, you have to take advantage of the momentum. Under that circumstance, sometimes you sacrifice technical expediency for the political momentum, otherwise you will lose it...Technical is only from my opinion about 25% because you need evidence not to go wrong, but it will go wrong so you might as well model it as long as the base concept is correct and the base concept has already been validated by experiences in other countries, it is also validated on a small scale by all pilots that had happened in the past and the committees themselves mobilizing themselves for insurance.

Adjei (2013) confirmed all of this when he noted, “we can never design a perfect system, we can never discuss an insurance, so we could go on and debate and debate. And so the philosophy at that time was that, you sail your ship and build it at the same time. You just need to check and see if the ship can float and there were certain elements to make sure that the thing can take off”. Seddoh (2013) also made a similar argument in the quote below, with respect to the extent to which the design was shaped by technical analysis, arguing that,

Technical analysis is only from my opinion about 25% [of the number of factors that influenced the policy] because you need evidence not to go wrong. But it will go wrong so you might as well model it as long as the base concept is correct and the base concept, [in this case] had already been validated by experiences in other countries. It had also been validated on a small scale by all the pilots that were conducted in the past and the communities themselves mobilizing themselves for insurance. Once that concept is already validated in real life evidence and real life field experiment, you do not need another technical opinion from so called experts to be able to go ahead to do what is right. You might miss that window of opportunity that has opened at that time, and so with that expedience you just have to go ahead.

Technical analysis was also sidelined in determining payment modalities. As Akanzige (2013), a key member of the premium committee emphasized, “in one of the meetings, we were there trying to deliberate the premium when one [man’s name withheld] ...came from castle [the seat of government] and said that government has decided that the premium should be between

GH¢7.00 and whatever..., so we said that then other alternatives should be found” (Akanzige, 2013). Thus, as Seddoh (2013) added, “if we continued engaging only the technical people and tried to get the technical design right, we would never have been able to introduce the insurance”.

Moreover, the team had a strong sense of purpose, motivation and the desire to create a path-departing change, even without the support of international actors. In the first place, as Adjei (2013) reported, “there was a compilation by ILO that in developing countries, insurance will not work because there was too many unemployed, because social health insurance practically means taxing – payroll tax – to finance health care, but the proportion of the population that was on formal payroll was not big enough to sustain it”. In a similar light, Agyepong (2013) argued,

When we started, a lot of the development partners who were actually in Ghana were sceptical. In fact some of them even tried to discourage us...I think they actually tried to discourage it... they were kind of sceptical, it can't be done. It's in a low income country, largely informal sector so I think some of them really thought Ghana was over reaching itself and so on and so forth and I think it couldn't have flown with them. It [finally] flew because the local actors said we don't care, government said we will do it. So the general idea was that it will not work so nobody took it seriously. Yea they felt this couldn't be done.

Beyond this, as Amoh (2013) stated, the international agencies “were not in agreement with the speed [fast pace] at which we were moving ...they thought that how can you have a health insurance in just a year or two years, while Germany took 100 years and so forth”. They thought that “Germany has taken 130 years... so they couldn't see how we could do...the health insurance in Ghana within less than 10 years”. In the passage below, Seddoh (2013) notes additional areas the external agencies expressed dissatisfaction with the NHIS.

The external partners were never interested, they didn't want health insurance in the first place. It was first seen as socialism and most of our development partners were capitalists, so they didn't really accept that anything should be free. That is their first position. Secondly, they didn't like our design, most of them were already financing community based schemes and anything national they didn't trust government to do it so they couldn't trust government and so they were not prepared to centralized social insurance as it were. Thirdly they saw it as creating another Nkrumah-type NHS...The

international community was very milky at a point in time. ..In one of the quarterly business meetings, they walked out and threatened to go to the presidency and parliament to go and protest it. They called their bluff.

The design team was, however, bent on pursuing their agenda without international support. As indicated, they were motivated by the successful introduction of health insurance at the community or informal level. They were also inspired by the positive public opinion around the policy, as well as the tendency of a government to lose the next election if they failed to carry out the promises they made during the election campaign (Agyepong, 2013).

To introduce the policy without external interference, the team backed out of all activities that involved international agencies. This situation was captured in the annual review of the Programme of Work (POW), which reported the following:

Donors have complained of being excluded from planning and policy discussions in 2002 and the MOH itself admits it wants some space to itself to determine its focus and priorities. Informal relations between MOH and partners have cooled considerably compared to 2001. MOH officials report that they require space to develop their own thinking and position on key issues. Some partners have interpreted this as a snub; as a result there has been a loss of goodwill, which is an important ingredient in effective team working...On the whole MOH and donors both want to improve the efficiency and effectiveness of the health services. However, tensions have risen because of different expectations of implementation pace and the extent to which donors were involved in defining policy and core MOH functions (Coleman, 2011, p. 36).

The final but perhaps most important attribute of the reorganized design team was its ability to establish a strong alliance with the cabinet and, particularly, the president. This approach was crucial for sustaining the agenda because, as indicated, some members of cabinet were initially apathetic towards the NHIS (Afriyie, 2013; Anane, 2013). After presenting their work, however the team brought a majority of cabinet members on board to support its design. Adusei (2013) explains this strategy in more detail in the following passage:

We did presentations in cabinet, about two times. In fact, it was the first time that I saw civil servants giving presentations to cabinet. Normally, in cabinet, it is the minister that has to do a presentation, civil servants are not allowed. But for the first time, it was Dr. Arko [chair of the design team] that did the presentation, and afterwards, the whole thing was packaged to parliament.

The president was also singled out and frequently briefed on the design process as a way to secure his support. As Adusei (2013) reported,

Government had to really support it. For the policy to work, it needed the full backing of the government. Indeed, in Ghana here, it must be the president because he has executive powers in this country. If it is just the support of the minister, it is nothing; you really need the support of the president for ...every big project to work. Otherwise, it is not going to work. And this one [i.e. the NHIS], the president himself was involved. This is because once a while, we went and briefed him. Yes, we had the opportunity to brief the president.

Co-opting the president was important because, as one of the team members noted, “health insurance is a security risk; if we don’t do it well we will have a lot of problems, including bashing from the community...so he was involved” (Adusei, 2013). Afriyie (2013) confirms this.

I used to go and give him [President Kufour] good briefing not on the working day, but Sundays. I used to call him wofa [uncle] and I will give him a good briefing day by day- always premising it on sound concepts ... I told him, it may not be scientific but ... this thing will sell, and I even pointed out to him that he should listen to the villagers because at that time we had done some marketing, we had done some education and all that. At that time it was not for nothing that when you heard the cocoa farmer or even a yam farmer from Konkomba [a village] talking about the health insurance...it looked as if they were even more knowledgeable about health insurance than let’s say an the average teacher.

The president also utilized the opportunities offered by these briefings to interrogate the design team so as to share the plan with other countries that were interested in the Ghanaian reform. As Adusei (2013) stressed,

Apart from people inside here [Ghana] who were doing it, there were people outside who were also very interested and actually listening to whatever is happening in this region, so he [the president] was aware and actually asking very relevant questions and the way he wanted to go. Apparently, he agreed on all the things we said about the policy.

Over time, these executive briefings appeared to have paid off; they made the government bolder in the face of international pressure at subsequent stages of the policy process.

However, some of the design team’s decisions were shaped by policy legacy rather than strategy in the strict sense of the word. One example includes the decisions on the type of drug

to be supplied under the policy. When asked about the factors that informed the drug list, the minister responded,

Fortunately, we had a national treatment guidelines already there to guide the committee that was set up to work on it. I remember I said that I didn't want to complicate things ... So for the drug list, I said any drug that can be prescribed by a practitioner in a clinic... should be on the list. Even before the health insurance scheme was passed, we reviewed it [the existing drug list] and added some more items to it. So you could find about 90% of those drugs on the NHIS drug list.

Similar factors appeared to have shaped the policy's exemption scheme. Beyond policy legacy, the exemption scheme was influenced by cultural and experiential factors, as could be inferred from the quote below by Adjei (2013):

Although it [the NHIS] was supposed to be pro-poor (i.e. to address the needs of the poor), we didn't have targeting mechanism for the poor. Hence, we used big groupings. So everybody above 70 years was not supposed to be able to afford the annual contribution. Children would also not be able to afford it. Later on pregnant women were also included as indigents... We ended up exempting almost everybody. And if you have a very large exempt group, then you have to find another means of financing their health and that was where the tax element...the concept of the VAT or National Health Insurance Levy, came up.

The minister confirmed the cultural and experiential bases of the exemption scheme when he was asked why the design team fixed the exemption age for the aged at 70 years minimum instead of 60 years, which is the official retirement age (Sorsey<sup>59</sup>, 2013).

We set it at 70 because we knew that even operationalizing it will be difficult. Most Ghanaians do not know their age, especially, in the informal sector and even in the formal sector, a lot of people have sworn affidavit that is not their correct age, we have a phenomenon called civil service age. Unfortunately, you [we had to] work against that because somebody may be 65 years and yet when he goes to civil service he will say he is 59 years (Afriyie, 2013).

The above passage suggests that the experiences of being unable to identify people who truly deserve to be exempted influenced the decision to set the exemption age for the aged above the socially accepted level. While this has the tendency to reduce excessive health care spending on the part of government, it could as well have an adverse impact on the people who have kept their true age and so deserve to be exempted under the policy.

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<sup>59</sup> Sorsey is the executive director of Help-age, one of the non-governmental organizations that suggested amendments to the NHIS through a memo to the parliament of Ghana during the enactment of the NHIS.



### **6.3.3. Policy Adoption**

The draft policy was submitted to the Minister of Health, who tabled it before the cabinet and then parliament. The aspects of the draft policy that attracted the most attention and debate at the cabinet level related to the funding modalities, particularly concerning the introduction of the NHIL and the three main schemes to be incorporated into the policy.

The original term used by the design team with respect to the NHIL was Value Added Tax (VAT). The proposal to increase VAT became a controversial issue in cabinet because of a number of reasons. It had been introduced in the 1990s by the NDC in the face of opposition by the NPP government, which was in the opposition. At that time, as Anane (2013) emphasized, NPP members of parliament “walked out” of parliament in order to register their opposition to the policy. Beyond that, the NPP organized a massive demonstration, which was themed, “Ku mi preko”, i.e. “you better kill me than let me live under VAT” in Accra (Seddoh & Akor, 2012). The VAT was seen as a “regressive tax regime” (Afriyie, 2013) and, as Afriyie (2013) noted, “any regressive tax regime impacts negatively on the poor”. Given the above background, most members of the cabinet thought that increasing the VAT was politically risky. In particular, as Afriyie (2013) stated, “there were some opposition from even within the cabinet on the VAT... Yes a lot. They said that if there is a proverb that says, if it moves like a cow, eats grass, and as big as a cow then it’s a cow”. In other words, some members of cabinet thought that, whether it was earmarked for health care or not, a VAT would be risky to implement. This issue reportedly led the cabinet to invite the design team to explain and explore possible alternatives (Amoh, 2013; Adusei, 2013).

Most of the design team members interviewed indicated that the VAT was needed to provide seed money for the proposed policy (Adjei, 2013; Seddoh, 2013). Consequently, as a member of cabinet at the time indicated, “we concealed it” as a National Health Insurance Levy

(NHIL) instead of a VAT (Afriyie, 2013). Seddoh (2013) confirmed this. He noted, “we had to change the name [VAT] to National Health Insurance Levy”. Also, cabinet reduced the rate of this levy from 3.5% to 2.5% to minimize its impacts on the public (Seddoh & Akor, 2013). According to Seddoh and Akor (2013), it took about half a year to come to an agreement on the financial modalities.

In addition, whereas cabinet approved the three types of schemes the design team had suggested, it decided to layer the PMHIS and PCHIS on the top of DMHISs, which were the new schemes the government intended to establish. It did so by inserting an additional clause into the proposed design that gave exclusive room for the DMHISs to access subsidies from the central government. As could be inferred from the passage below, besides technical and ideological reasons, cabinet’s intention in layering the existing schemes over the new ones was to ensure the dominance of the latter over the former. As Afriyie (2013) noted,

In fact, if I had my way, I would have shrunk these mutual health organizations. I saw this as a historical thing and during our era, we had no choice because of the structure of our Ghanaian situation. If you decide that you will use the private mutuals as the spring board for your action, in 4 years, we will be out of the place [i.e. power] so that was why [we didn’t collapse the existing mutual health organizations]. And this one, the government could actually influence it [the decision].

In a manner not clearly visible to the constituencies affected, the layering strategy was intended to make the existing schemes disappear over time. Andoh (2013) confirmed this.

There were communities that had community-based health insurance schemes, we are not saying that they should collapse, you go ahead...But if you agree to collapse into the district-wide mutual health insurance schemes, you would get funding from the government - and this is exactly what happened. It was a nice way of telling them that the fragmented schemes...will not help...their financial base is too small and insurance thrives on numbers. So there was the need to bring all of them together, but you cannot force them. You can incentivize them for them to buy into.

The above quotes align with the argument of other members of the design team that the merging of the schemes was a backstage deal, done without prior consultation with the design team members, who thought that giving all the three schemes equal treatment was the best way

forward. When asked to explain why the three different insurance policies should be clumped under the NHIS, Agyepong (2013) responded,

There was a particular group that felt threatened because their major opposition was coming from the already existing mutuals which were saying we don't want to be swallowed up. We like our independence. We are succeeding. We want a place at this table verses the desire that everybody must come under one umbrella. So it was a small group of people who had a lot of political links, they changed, I remember so well, they changed the wording at the last minute, I saw it and I said what are you doing this is going to create a problem and they said we will have private mutuals and public mutual...If you want to get any of it, you have to get the public mutual that tolls the line. And by virtue of putting that clause in the line, most of the mutuals which could have ended up as they put in the category of private mutuals were the already existing mutuals and they couldn't succeed and reach out to the poor ...so they all joined the public system... Yes, so this is my take on what happened over here, it was a purely self-interest motivated [decision]. But, again, it comes to the issue I said about power - they did have very strong political links.

Adjei (2013) confirmed this observation,

The policy dialogue [at the design stage] was informal sector, formal sector which is linked to SSNIT and the private commercial, but when the law came, we have merged the formal and informal together and created two private groups, the private mutual and private commercial, so people couldn't recognize the policy dialogue in the nature of the way the law was developed. So that caused a lot of agitation and protest from the trade union, from even some of the donors, like DANIDA who was supporting us at the beginning and several others. But you really needed to pay attention carefully to see that they have twisted the system slightly... That was the first time, so the district mutuals were set up as private entities and then the money had been collected centrally by the government and it was channelling the use of that money through these entities.

Beyond demonstrating that power plays took place during the reform process, the above passages reveal the extent to which the adoption process created additional windows of opportunity for strategic actors, such as the minister, who also served as a member of cabinet, to shape the NHIS beyond the capabilities of other members of the core design team. It also confirms the importance of presidential support for policy change.

Two months afterwards, i.e., in March 2003, the draft policy was delivered to the Attorney General's Department for review and conversion into a bill for parliamentary approval (*Daily Graphic Newspaper*, May 15, 2003). In Ghana, there are four stages to the parliamentary approval process: First Reading, Second Reading, Consideration and Enactment (Coleman, 2011). The first reading occurs when the bill is first introduced to parliament, after

which a committee is set up to critically study the bill and submit a report for the beginning of the second reading. This is followed by consideration and finally enactment.

The Minister of Health introduced the NHIS bill to parliament for the first reading on July 11, 2003, barely a week before parliament went on recess under a certificate of urgency or need, a strategy that suggested that parliament would not have adequate time to debate the bill before passing it into law (Alatinga, 2011). Due to the nature of the bill, it was referred to a parliamentary joint committee on Health and Finance for study; the committee would report back to parliament as soon as possible for the beginning of the second reading. As Tony (2013) explains, “it was a purely health issue, but because of the funding aspect, the speaker [of parliament] thought the two committees should look at it”.

The committee published key aspects of the bill in the national gazette, requesting memoranda from various stakeholders for consideration. In the views of the leaders of interest groups interviewed for this study, this was the only opportunity for them to exert their influence on the reform (Sorey, 2013). Hence, in 2003, 16 memoranda were submitted to the joint parliamentary select committee on the policy, one of which was submitted by Help Age (Parliament of Ghana, 2003). In fact, Help Age submitted another memorandum during the repeal of the policy in 2012. In the passage below, the Executive Director explains the content of both memos.

The memos were mainly on the reduction of the exemption age for the aged. That was because we had then gotten a national aging policy, which purged old age at 60... even though we have not given it a legal backing. When I asked, can we reduce the age from 70 to 60? At the last engagement with the select committee, they were telling me that unless they understood the financial implication of reducing the age, it will be difficult to do so (Sorsey, 2012).

However, Help Age was not able to produce the requested information because of lack of official data on the subject, leading to the organization’s failure in its pursuit (Sorsey, 2013). Expressing his view on the legislative process, Sorsey (2013) noted,

One problem with policy development in this country is that it is almost like a confidential [matter]. We don’t announce policy at the formulation point. We never

complete the loop, unless it makes us popular. You listen to it and you will be there and they tell you this people submitted this bill to parliament and you ask yourself when did they start writing it? You will be reading newspapers and you will come across a publication that, this bill has been submitted to parliament for comments, for submission or whatever it is. Sometimes they give you a maximum of two weeks when you have not even been given a copy of the bill to write your comment. So what comments are you talking about? For the national health insurance, we never saw the draft bill in order to provide an informed comment. So the memos we were submitting were basically memos that were indirectly saying that please, in case you have not considered this issue, then consider it. And the memos were not based on the observation that a particular article or sub section would be ABCD, so you should change it. No! It is a weakness in our parliamentary system. They publish it [a bill] when it is not even available to the public, so what do we mean by memo? I have not seen the thing [bill], yet you are saying that I should suggest or submit a memo. Why didn't that happen at the ministry level before the drafting of the policy was done? The information should be that we are going to draft ABCD policy, so... whatever direction or whatever information you think should be considered, let us have it so that we can include it. Why was it not there at the drafting level?

The implication here is that even legislative opportunities for interest groups to shape policy change remain limited; they are not given access to a full draft of a policy to be able to properly interrogate its content and shape the reform trajectory in any significant way. In the passage below, Sorsey (2013) also identifies other key limitations with respect to memo submission during the legislative process.

You go there and they don't ask you any relevant question about the memo. They give you the opportunity (e.g. help age Ghana) ...we are listening to you... We give you 5 minutes, any question? The members [then responds that] no question. Then they thank you ... That is what we are wasting time on. So when you talk about policy development, I have my problem with the process already and the [low] quality of the outcome is because the process is faulty. That is how it is.

In addition to being inefficient, the opportunity interest groups had to shape the NHIS through the submission of memos was dictated by the parliamentary committee, which was dominated by members from the party in power. This made it even more challenging for the interest groups to adequately shape the policy. As Sorsey (2013) pointed out,

You will submit a memo and you will be called to go and defend the memo. Before that, they knew we were talking about the issue outside. So the select committee will invite you. First they will just invite stakeholders they think can help them and then they also invite people who have submitted memo. I am sure if we had not submitted memo, they will still invite us but I don't think that opportunity will be adequate for us because if they invite you, it is what they want to hear that you tell them.

In the face of these institutional obstacles to change, some groups adopted other means to pursue their interests. They used the media, resorted to street protests, wrote letters to core government officials and organized direct engagements with key parliamentary actors. For example, led by the TUC, labour used street demonstrations and issue statements to protest the government's unilateral decision to deduct 2.5% of their SSNIT contributions to finance the NHIS, arguing that it was tantamount to collapsing their *bona fide* social security fund (Kuntulo, 2013; Mensah, 2013; Tony, 2013). The TUC then asked the government to withdraw the bill in order to allow labour to decide on the issue (Kuntulo<sup>60</sup>, 2013).

Unlike the TUC, however, the African Women Leaders Network dealt directly with key parliamentary actors to push family planning onto the NHIS. Although it was referring to the 2012 amendment rather than the 2003 reform, the account of the organization provides additional insights with respect to how interests in Ghana shape policy change despite institutional difficulties to do so. As Aboagye<sup>61</sup> (2013) described,

What we did was to engage with the various committees of parliament that had direct impact on the passage of the NHIS bill. So we worked with the women's caucus. We worked with the parliamentary health committee and the parliamentary select committee on finance. We were in constant engagement with these three caucuses. We held a number of meetings. We spoke to the leadership of parliament. We convened them in October 2011 just to encourage them and to ensure that the bill was before parliament. We did that because from our understanding when a bill goes through a number of these processes some items are often dropped off the list. And so we wanted to fight and ensure that [family planning] commodities and services were maintained. We had opportunities to take some members of parliament from the health committee to meet some of our other partners. I think in 2012 we took about two or three sets of parliamentarians to different meetings where they had the opportunity to meet with some of our other partners in family planning initiative and to share experiences with the parliamentarians from other countries that were much more advanced in family planning issues...So we wanted to give them the opportunity to learn from and share with other parliamentarians from other countries. Basically that was what we did. And like I said, it wasn't a solo effort; it was a joint effort that took a lot of time, maybe one and half years.

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<sup>60</sup> Kuntulo is an executive member of the TUC as the representative and General Secretary of the Health Services Workers' Union.

<sup>61</sup> Aboagye is a representative of the African Women Leaders Network during the NHIS development process.

Basically, the group sort of “shut them up in a room, gave them lunch, gave them per diem, talked to them and ensured that they had it [our interests] on the bill” (Aboagye, 2013). Using this approach, the group was able to bring key parliamentary actors on board, such as Dr. Richard Anane, Matthew Opoku Prempeh, Honorable Cletus Avoka, Muntaka Mubarak and Gifty Kusi (Aboagye, 2013).

Other groups that opposed the passage of the NHIS involved the main opposition political party (NDC), the Ghana Network of Mutual Health Organization (GNEMHO) and External Agencies such as DANIDA, the United States Agency for International Development (USAID) and the World Bank. Using venues such as parliamentary proceedings, the NDC attacked the 2.5% NHIL, arguing that it would worsen ordinary people’s livings (Akanzige, 2013). Referring to GNEMHO, Coleman (2011) argued that “by 2002, the community prepayment schemes had matured into an interest group ready to influence public policy” (p. 24). Through meetings and media reports, the members of GNEMHO also complained about how the law discriminated against them and asked the government to give them the same status as the government-sponsored DMHISs (Coleman, 2011). As key stakeholders in CBHISes, external agencies such as DANIDA and the World Bank also joined in the opposition to the policy, asking the government to give up its role in health insurance to the existing CBHISes (Bruno<sup>62</sup>, 2013). As Seddoh (2013) noted, “most of them were already financing community-based schemes and anything national [such as the NHIS], they didn’t trust government to do it. So they were not prepared to centralize social insurance as it were”. Adjei (2013) added that, “DANIDA, who was even supporting us a bit, was interested in community based health insurance schemes”. Confirming the above, Akor (2013) also indicated,

DANIDA started supporting district health insurance in some parts of the country to assist communities or districts that wanted to start their own health insurance. And they provided them with technical expertise ... at that time. Chris Atim was the lead person in Ghana with a PHR [Partnerships for Health Reform] group to provide technical or

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<sup>62</sup> Bruno is an officer of the Planning and Monitoring Unit of the National Health Insurance Authority.

capacity building for those who wanted to start their own scheme. But there was a problem in terms of how fast they were establishing the schemes in the districts. It took a long time. And even from their experience, we should have looked into why the growth of the existing schemes was slow so as to modify our strategy in terms of establishing new ones. That was also why people thought that we were moving [too] fast.

Thus, from all indications international actors were not in support of the government's agenda to introduce the NHIS. As such, they "threatened to go to the presidency and parliament to go and protest it" (Seddoh, 2013). Confirming one of their threats, Afriyie (2013) noted,

I don't want to mention the western countries; they actually wrote letters - it's not like they whispered, formal letter – indicating why our proposal was flawed and why they thought it won't work behind my back. They didn't bring it to me and it was a couple of days to the passage of the bill... And it was coming from a western government that, I want to believe, meant well. For Kufour [the president] to have read their letter, and yet said that he was going with Afriyie's [my] proposal was the ultimate compliment.

Beyond showing that the president supported the reformers, the above quote suggests the extent to which their close relationship with the president, as discussed above, may have contributed to deepening the president's faith in the reform, as well as in keeping NHIS high on the political agenda. In fact, the decision to introduce the NHIS was also risky because at that time donors were needed to support the implementation and sustenance of the policy since Ghana was a HIPC. External agencies identified this limitation and tried to exploit it. As Anane (2013) indicated, "I remember Friedrich Ebert Foundation [of Germany] came to me and said that...I should rather make it a [community-based] mutual scheme and that they were ready to help if I made it a mutual scheme. I listened to their presentation and the only question I asked was whether that was what they had in their country. They didn't answer".

In view of the above protests and the polarized nature of the discussions surrounding the bill, the house gave the committee permission to organize additional stakeholder consultations across the country (Kusi, 2013). These stakeholder consultations offered opportunities for the committee, together with members of the design team, to address



stakeholders' concerns (Kusi<sup>63</sup>, 2013). As Akor (2013) noted, "parliament had to move us [the design team] around the country to also go and listen to the people's view to inform the bill". Depending on the committee and design team's own assessment regarding the credibility of the complaints and how much they could affect the fate of the policy, strategies ranging from inaction, sidelining, framing, compromise or compensation to accommodation was employed. For example, the committee saw the opposition of labour as a credible threat not only because unions were the true owners of the social security fund, but also because, by that time, some of them had formed their own mutual health insurance schemes. As Afriyie (2013) observed, "when we were starting, I noticed that the labour group had gone far in forming a health insurance scheme of some sort with the collaboration and support of ILO and they were even on the verge of receiving technical and financial support from the ILO, and here we came - we brought a system we wanted to subsume it on them-so they were very upset". Additionally, as the minister added, "they were going on labour agitation... and it had to take a lot of skills from me and my officials... Their Secretary General had taken a militant stand. We managed them but they were still unhappy" (Afriyie, 2013). In addition to this, labour unions are typically the most vibrant vested interests in Ghana, so the inability to address their concerns was interpreted as potentially disastrous for both the policy and the government in power (Hutchful, 2002). With the 2004 elections just a year away, it was thought that if the concerns of labour were not addressed, it could adversely affect the fate of the policy, as well as the government's chances for re-election. As Afriyie (2013) highlighted, "time was in essence, three years on our mandate politically speaking, so there was no time. So fortunately, 2003, the bill was passed into law (Act 650)". Yet, the reformers also knew that without the 2.5% contribution from labor, the policy would not survive in terms of funding (Adjei, 2013).

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<sup>63</sup> Kusi was a member of the parliamentary delegation that travelled across the country to solicit ideas from the grassroots in order to enrich the NHIS.

Based on these considerations, the committee decided to enter into negotiations with labour, a process that ended with a seemingly generous compensation for labour. For example, as Adjei (2013) notes in the following passage,

There was a compromise with the labour group; we could have charged them at the point of registration or taken their monies from their payroll for the social health insurance policy. Basically, they were not ready to contribute from their salary towards health insurance. So what the government said to the workers was that, ok, we will borrow from your SSNIT contribution because we need the money to finance the scheme. We will borrow 2.5% from your social [security] contribution. When it comes to the time you will be going on retirement, we are hoping that your social security money would have been adequately invested. It will make up for the money that we have borrowed so that you would not lose any benefit from your insurance when you go on retirement.

However, as to whether the money taken from the workers' social security fund to finance the NHIS was really a loan is still in doubt. As Seddoh (2013) argued when asked about the deal,

Actually borrowing is yes and no. Yes, because you are taking workers money that is guaranteed by government.... You are borrowing in the sense that it's not your money; you are taking what is for workers. It belongs to a particular group. But you are not paying it back. What government has done is to guarantee that if any worker at any time goes on pension, it [the 2.5% deduction to finance the NHIS] will not affect their pension.

A representative from labour also confirmed the above argument. He said, "government literally gave a guarantee that in the event that the monies (i.e. the 2.5%) they were taking were creating a problem for SSNIT, government will make good [available] whatever shortfall arises" (Kuntulo, 2013). However, labour was also exempted from making additional payments in terms of their premium on top of their 2.5% contribution, which the government had agreed to take as a loan (Kuntulo, 2013). The implication of this is that, in addition to guaranteeing their funds, the government is also providing free health care for labour under the NHIS. Since pensioners are also exempted from premium payment under the policy, labour enjoys free health care till death, as long as this aspect of the policy is maintained. This may be interpreted as unfair to workers in the informal sector who are required to pay an annual premium even though they generally earn less income than their counterparts in the formal sector (McIntyre, 2007). The argument about the unfairness of the policy, nevertheless, depends on whether the

government is able to guarantee the social security fund in the event of a bankruptcy. My investigation, however, revealed that the concession given to labour in the NHIS law was part of the strategies employed by the reformers to build additional constituencies in support of the policy change. This argument is based on the observation that no terms on the said loan appeared to have been officially signed between labour and government.

In order to solidify their achievements with labour, the reformers buttressed the negotiation and compensation strategies with ideational frames. For example, the NHIS was commonly framed as being in the interests of workers. The reform team also informed labour that, “you must live healthy because if you don’t and you die, there will be no pension. So if you keep this 2.5%, and you are sick and you die, then you won’t go on retirement to be able to enjoy the 2.5% of your pension. So use the 2.5% now to secure your health so that you can live and enjoy your pension” (Tony, 2013). In a town-hall meeting, Amoh (2013) used a similar strategy. He asked,

What do you use pension for in your old age? It is mostly health issues [he answered his own question]. This health insurance will take out your household health expenditure off your budget - individual and household health budget. If you have children in the household, grandchildren and the rest, they are all covered by the health insurance. You don’t have to pay anything. Your wife will have to pay for her own insurance, but if both of you are aged, then you don’t have to pay for health insurance. So, for your diabetes and whatever disease you have, you don’t have to pay anything... So when I told them this at the Teachers Hall, they agreed.

Furthermore, the reformers built a strong public opinion at the grassroots level in support of change. As Afriyie (2013) indicated,

I made sure that the rural people were on my side and for a long time, the air waves had been liberated, you should hear somebody from Domaa Ahenkro [a small town] speaking about health insurance, especially. Remember that even before the bill was passed, some institutions were given healthcare benefits so we will go to Ejisu Juabeng [district] and bring those who support the policy to speak good on the policy on our behalf.

By directing attention to the informal sector, they came to be much more knowledgeable about the NHIS than even the formal sector. Afriyie (2013) argued that it was the support from those

in the informal sector and rural areas that enabled reformers to kill labour and the NDC's resistance to the policy.

The labour movement thought that they had put on a good fight. But at that time, the political environment was such that the labour group would have been labelled as selfish and all that. That's why I am a politician. Because the informal sector was such a huge group, before we introduced the policy, I had made sure ...that we had marshalled them on the social front. Therefore, we heard people saying that let's bring it on, let's bring it on... We went round the whole country because we thought that there were odd voices here and there, led by the NDC, our political opponent.

The reformers also solicited the support of the media. For instance, as Seddoh (2013) noted, "we trained them [the media] in the things [about NHIS] in order to create diversion sometimes... We used them in diversion tactics [to divert labour's attention from the SSNIT contributions]. When we were negotiating around the SSNIT, we kept on the open feed in the VAT debate which we knew we had already won to be able to divert their attention from the SSNIT issue. We deliberately manipulated the system".

It was not only labour, however, that resisted the 2.5% SSNIT contributions. The executives of SSNIT also did. To counteract them, as Afriyie (2015) noted,

I just wrote a memo to cabinet about SSNIT. I said that I was not talking about embezzlement, I was not talking about corruption... Those were not my beef. My beef was that they were having it too easy: they were taking so much money from Ghanaians and paid lower benefits to them. So I brought a paper, a complete paper about the industrial average [of pension payment] across Africa and that was what convinced my government... otherwise, you know this institutional thing, they would be fighting me. So we got our way. We said to the SSNIT people, we were forcing their management to give workers the same benefit that they were given in the past [i.e. before the NHIS] and that the government was going to act as a guarantor, so that even if they defaulted [because of lack of funding], government would then stand in and that's what squared the argument.

In this context, in addition to the support obtained from the above appointment, the reform team researched the operations of SSNIT in order to obtain key information to sort of blackmail, or blame the perceived collapse of the social security fund on, the leadership of SSNIT. The team also managed to convince the government, which was determined to take money from SSNIT. As Seddoh (2013) noted, "SSNIT did not have a say because the president

made a decision, SSNIT didn't really have a say. They were comfortable. They said that yes, of course, you can borrow the money. They used the term borrow”.

Unlike labour, the NDC's request to withdraw the 2.5% NHIL, which it sometimes referred to as VAT, was thrown out. The committee used these opportunities to explain how different from one another the VAT and the NHIL were, despite their similarities (Agyepong & Adjei, 2008). Also, instead of imagining that it would create hardship, the committee stated that the NHIL would relieve Ghanaians of the flawed user fee model implemented by the NDC (Tony, 2013). To a large extent, the design team also portrayed the NHIL (VAT) as a way to bridge the inequality between the rich and the poor. This can be seen when Afriyie (2015) commented that,

Like I have done with the watchman, I said, look at me, a medical doctor, I earn so much. When you take 2.5% of my salary, how much? A lot! ... I also told them that when they drank beer [foreign wine], there was VAT on it. When they took akpeteshi [indigenous wine], there was no VAT on it. When they took palm wine [local wine], cassava [local food stuff], there were no VAT on them, but when they took spaghetti [foreign food], they went to restaurant [because they were rich], and when they smoked cigar, there were VAT on them. Those were the languages that we used, and the people embraced them.

Using messages like this, the reformers intended to explain to the ordinary Ghanaian that the NHIL was in their best interests, as opposed to the interests of the rich, and so they must support the government in introducing the policy. It was also intended to create the impression among the majority poor in Ghana that opponents of the NHIL were the few rich people in the country, against whom the poor should protest. In the end, the NDC's concerns were branded as mere political gimmick rather than as the result of a detached scientific policy analysis (Tony, 2013).

In the same manner, the concerns of GNEMHO and external agencies such as the World Bank were discounted. It was possible to do so because some members of the committee saw the association as a potential competitor to the government's agenda and their own personal interests (Agyepong, 2013). GNEMHO's challenge was that not only did it not possess the

power to veto the bill, but also many of its members were located in rural areas and, they were few in number. As such, they could not turn the political landscape against any policy change on their own (Agyepong & Adjei, 2008). For powerful external actors, as indicated above, government limited its engagements with them in order to prevent them from stopping the reform.

By 19 August 2003, when the committee finished dealing with the above matters and submitted its report, parliament had already gone on recess. Nevertheless, members were recalled on emergency grounds in order to consider the bill. The members from the opposition failed to show up, giving the NPP the opportunity to neglect key legislative procedures in order to fast-track the approval process. For instance, as Coleman (2011) indicates,

The Joint committee on Health and Finance presented its report. That same day the Minister of Health requested the suspension of Standing Order 80 (1)...On August 20, 2003, the bill reached the Consideration Stage. The Minister of Health requested the suspension of Standing Order 128(1)... the Consideration Stage continued through August 21, 22, 25, and 26. On August 26, 2003, the Minister of Health requested the suspension of Standing Order 131 (1) (p. 29).

In other words, both the second reading and the motion to move to the second reading were pursued the same day, contrary to the 48 hours interval required under Standing Order 80 (1).

A similar thing happened when the bill was moved from the second reading to the consideration stage on the following day, instead of the 48 hours required by Standing Order 128(1). The law was also enacted that same day (August 26, 2003), without the 24-hour interval required under Standing Order 131 (1). While suspending those standing orders was not necessarily illegal, they provided an additional explanation as to how the strategic choices of the reformers shaped the final policy outcome. In September 2004, the LI to guide the implementation of the NHIS was passed in a similar manner.

#### **6.3.4. Policy Implementation**

In the passage below, Adusei (2013) explains the importance of policy implementation.

If you have a law and you don't create an institution and enabling environment for it to operate, it is still a law. So we have so many laws in this country which are just laws. Health insurance could have been one of those laws if we didn't actually put in conscious efforts to set up institutions at various levels, especially at the district level to make it happen.

In other words, the reformers saw the implementation of the policy as crucial. The first strategy the reformers employed to achieve change effectively, while at the same time guarding the policy against being hijacked by the existing CBHISes and their partners, including powerful external actors, was to decentralise implementation power to the local governments, particularly the District Assemblies. As Adusei (2013) states,

We gave money to every DCE [District Chief Executive] to set it [DMHIS] up. To set the programme up is not just by word of mouth, but you have to get a building, get a place, employ people into it, get the resources they need, issue health insurance cards, recruit IT people and all that. And we wanted the districts to actually do that... We got consultants for the district chief executives. Consultants who have crafted the law and who were part of us were recruited to go to the various districts. We gave them money, paid them money to help them set up the schemes.

This means that, in addition to decentralising authority over implementation, staunch supporters of the policy originating from the core reform team led the implementation process on the ground (Amoh, 2013). For instance, the chair of the design process was appointed the Chief Executive Officer (CEO) of the NHIA (Agyepong, 2013). In addition, some of the political associates during the design process were made consultants, and were tasked with helping set up the DMHISs (Adusei, 2013).

Moreover, like all the other stages of the policy process discussed here, the implementation process received strong political backing since the president had made it “part of the terms of reference of the DCEs, the District Chief Executives. They were asked to set up the mutual health insurance schemes in every district. And it was part of the terms of reference of the Regional Ministers as well” (Adusei, 2013). In other words, the president's appointees in the various local government units (districts and the regions) were charged with paying particular attention to the implementation of the policy in their respective jurisdictions. Adusei (2013) notes that, as a result of the decentralization of the implementation process, the team

was able to make credible achievements “within a very short time”. Afriyie (2013) confirms this.

As at 30th November 2004, for example, there were 15 [district] mutual health insurance schemes that were managing benefits and claims. 34 of them were ready to be operational and 44 who were collecting contributions...from the informal sector... Early as November 2004, even ... Jaman North, Jaman South, Tanor North, Tanor South, Brekum, Domaa, Akuapim North, Damango West, Asuajaman, Nkuransah, Ajusu Jwabeng, Peshi, Okowoman, West Gonja were managing claims and benefits ... That means we had moved very, very, fast for example in the [district] mutual health scheme. A key manager, an accountant, publicity officer, claims manager, management information systems manager, data entry clerk and so on and so forth had been recruited. And so [in terms of] personnel, we had 58 districts with all positions filled, 5 positions for 52 schemes and so on and so forth. By 2004, key achievements involved the LI, administration instructions...Our challenges were capacity development, ICT networking, accreditation, costing identification system. Before we even brought in health insurance scheme, one thing that people did not know ...was that, every place in this country where there was a human being had to have a unique address system. Even as I speak to you now, if you go to the villages, almost every village has a unique NHIS number and we did this from Apolonia to Zuaru, it was a big undertaking. We didn't make any farce about it because without a unique address system, we could not run an effective insurance scheme. Because I had brought in a decentralized system, this thing went on quietly even without Ghanaians being aware of it. The key success was that we did it and it was the platform on which this health insurance was done.

Beyond specifying the achievements of the decentralised approach, the above passage reveals the activities undertaken to implement the new policy. Some of those activities included providing residential address systems, recruiting personnel, accrediting providers, adopting claims management systems and issuing identification cards. Another benefit of the decentralised approach was that it enabled the various districts to take ownership of the policy.

As Adusei (2013) explains,

We were thinking that communities themselves should organise and relate to the health insurance, but we believed that if we have community based schemes, how many communities do we have in Ghana? More than 38,000 communities in Ghana. Are we going to have 38,000 schemes? So we thought that even if they should all be coordinated at one point at the district, that, at least, we can have communities representation at the district level in the form of boards. And then they can actually mobilize funds and bring it to the district-based boards. So we had district-based boards. We were proposing that in each community we should have representatives in the communities who will mobilize the community, get money from the community. People will pay the insurance premium or insurance whatever from community and they can bring it to the district and, of course, they will take their percentages, from whatever they bring. Yes, that is how we were seeing it and that is the reason why we



thought that it should be a scheme where the districts and the communities will work together to operate under the District Assembly.

Besides it being “owned” and managed by the localities, the decentralised approach also facilitated the implementation process. As Amoh (2013) indicates, all that was left for the reformers to do “was to supervise and regulate their [the schemes’] activities and monitor [them]”. The effect of doing so was that the policy was quickly rolled out across the country. Consequently, as Amoh (2013) adds, “we took them [our opponents] by surprise ... They realised that we were really on top of the issues”. Adusei (2013) confirms the above claim, indicating that, “if we hadn’t done this [the decentralisation], we wouldn’t have been able to implement it [the policy]”.

Beyond its ability to help with implementing the policy, the decentralisation approach also allowed reformers to build new constituencies to guard over the implementation process. Some of these new constituencies involved the various District Assemblies, board members, Regional Ministers, chiefs of the localities, and personnel of the NHIS such as managers of the schemes, as well as officers of the various health insurance councils and boards. Indeed, this strategy was crucial, as some labour groups had still not acquiesced to the reformers despite the generous compromises they obtained during the adoption process (*Daily Graphic*, September 25, 2003). In fact, after the implementation had begun, some labour groups demonstrated on the streets, threatening to sue the government for taking their pension fund. Turnout, however, was low (CSO 08, 2013). In turn, the Minister of Health took advantage of the situation to further engage labour and once again frame the social security deductions as in the interest of the workers (Coleman, 2011). In the end, as the labour officer again emphasised, “we realized that government had no other alternative...we realised we would be serving a national cause” (CSO 08, 2013).

Besides labour, the decentralised approach enabled the reformers to outwit external actors who had initially expressed misgivings about the policy. Agyepong (2013) confirms this

observation, arguing that, “it was as things moved on and we came out with a law and we started doing this and people realised we were serious then we started getting more support and ... now the pendulum has shifted where we are getting a lot of external support”. Describing this situation, Andoh (2013) notes that the external actors actually “wanted to associate with the success”. However, it appears that some of the international agencies also voluntarily gave up on their initial position. As Adjei (2013) notes,

But the good thing about the World Bank was that somewhere along the line they came in. In fact, I met one of them in South Africa and said please come and see what we are doing and advice, (he was an old friend, Alex Perg), and so he came in and saw what we were doing ... we have passed a law and all that. And he said, if this is what the government wants, we would, the World Bank, have to respond to the government needs. And so they went back to their headquarters, they sent a team, which looked at it [the policy] and said, well, it sounds crazy but this is what the government is doing and we will be committed to supporting it.

According to Adjei (2013), after the above incident, the World Bank “made provision for 15 million dollars grants to be used to run the insurance” in 2005, although “it didn’t get operational until 2007”. Nevertheless, according to some of the officials, “at that time...the money they were bringing in was not even need[ed]”, Amoh (2013) concurred. In the end, the operationalization of the World Bank’s support on the ground was delayed because, initially, NHIA officials “didn’t want them [the World Bank] to have a say in the health insurance and therefore didn’t want their money” (Amoh, 2013).

The first CEO of the NHIA and most of the consultants on the implementation process were relieved of their posts about three years into the policy’s implementation on allegations of financial malfeasance (Andoh, 2013). After this, what Agyepong’s (2013) calls the “shift in the pendulum” from local to external actors in NHIS implementation began. As indicated above, this shift was related to monetary assistance external actors offered. However, other strategies with ideational inclination were also employed to support implementation. For example, as Amoh (2013) notes, the international agencies were engaged in “making proposals and taking these people [authorities of the NHIA] to England, Holland, America, Canada and

all of these places, to go and look at their insurance schemes... They [also] tried to tell them that what we are doing here [in Ghana] is not correct". Thus, as Amoh (2013) adds, "by the time those guys [officers of the NHIS] came back, all of them, their minds had changed," and now supported external advice and involvement. Nonetheless, as the next section will show, this new development tended to limit local initiative and innovation, which undermined the potential sustainability of the new policy (Amoh, 2013).

In addition to the adoption of the decentralised approach described above, the reformers employed ideational framing strategies to increase support for the policy. In rural areas, for instance, reformers capitalised on knowledge of the local solidarity initiatives explained above to promote the core idea of the NHIS. For example, as Andoh (2013) noted, "we were drumming in the ears of the people that the NHIS is just like the funeral donations, it's like the *susu* that you make towards your finances. [The only difference is that] this one is towards your health so whether the person has it or not let the person contribute what he can and then we pool it together, government will support it and then everybody understood, so the concept was already there".

As part of their communication strategy, the reformers used the media to spread pro-NHIS discourse throughout the country. As a member of the implementation team (Andoh, 2013) explains,

I had to court the friendship of the media and use them to sing the good side of insurance. So I remember I was invited to Peace FM and on one of their programs (In those days there was one program that people really listened to, called *parliament on radio*. I don't know whether they still have it. I think they did it on every Monday at 8pm)...They talked about political issues so they brought parliamentarians to come and speak on hot issues so when it got to that time everybody in Ghana wanted to listen. So at that time they told them that today we are not bringing a politician but we are also bringing something that is dear to politics, health insurance, so everybody should tune in their radios and ask all the questions that they have. ..I went to explain a whole lot of things to them and they took it up and then subsequently I was invited to TV3 they also had a program on Tuesdays and Wednesdays...it was a Twi program, very nice, but these days they don't do it anymore...They also invited me to come and speak to health insurance. And when I went on Tuesday a feedback came that they wanted a repeat of

the program so the following Thursday I went and those who were not satisfied with questions or didn't have time to ask questions at the previous time also did.

As suggested above, the media also provided a platform for reformers to further explain key issues that were not clear to the public. This helped build additional constituencies in support of the NHIS. However, as Seddoh (2013) emphasises, the media "didn't understand what was going on", so they provided platforms to the reformers to sell their ideas rather than shaping the policy change process themselves.

Another factor of the success of the policy's implementation, as Alatinga (2011), noted, was that the schemes recruited "managers with political affiliations to the ruling NPP government" (p. 51). These recruits gave the implementation all the necessary political support. However, most of them had no "prior training on health insurance and how insurance works generally" (p. 51). One of the scheme managers noted that some of them had to work on the basis of "trial and error" as a result (Koah, 2013). Given that health insurance was relatively a new policy in the country, and that many of the personnel they recruited were not familiar with the concept, training programmes would certainly have helped to better implement the policy. However, because instituting the reform rather than technical expediency was the ultimate concern of the reformers (Rajkotia, 2007), training was neglected. The schemes did also employ a significant number of university and polytechnic graduates and service personnel who just needed jobs rather than necessarily being political (Seddoh et al., 2011). But, even then, the focus appeared to have been more on using them to boost support for the new policy and enhancing the government's reputation for job creation than as providing technical support for the policy.

Implementation of the subsidy system for DMHISs, as well as the generous benefit coverage, the membership premium and the exemptions, also enticed a significant number of people to enrol in the policy (John, 2013). As a result, not only had several schemes emerged nationwide by the end of 2005, as indicate above, but also, enrolment into the schemes soared.

For example, by mid-2010, about two-thirds of the Ghanaian population was enrolled in the schemes (Kotoh, 2013), and service utilisation had climbed remarkably (Asante & Aikins, 2008; Akum, 2014). However, increased enrolment disproportionately increased claim payments. They increased 367% between 2005 and 2006 (National Health Insurance Authority, 2010, cited in Akum, 2014). Besides the large enrolment, another factor believed to have contributed to the high claim payment was corruption and mismanagement on the part of some scheme managers and providers (Afriyie, 2013).

There have been other implementation challenges that are worth considering in this study. The first involves the implementation of the NHIL. As Awithey (2013) notes, instead of the 2.5% NHIL being deposited into a separate fund, it was and still deposited into “the consolidated fund, from which all government expenditure is made”. Consequently, “the service provider who is supposed to be paid 60 days or 90 days after he or she provides a service and submits a claim is not being paid” (Awithey, 2013). An official of the Ministry of Finance explained this problem on both institutional and pragmatic grounds, arguing that, as a tax revenue, the NHIL could only be legitimately collected by the Ministry of Finance, the sole body in charge of financing and managing national coffers (Tony, 2013). In other words, despite being an earmarked tax, the NHIL cannot be collected directly by the MoH or the NHIA because they do not have the mandate to do so. The challenge with adding the NHIL to the consolidated fund is that the government could be tempted to use it for purposes other than the NHIS (Akor, 2013).

Inquiring as to why the NHIS was generating less revenue than expected, the politicisation of the implementation process came up as a reason, among others. For instance, as Sorse (2013) notes, “immediately this thing started, politicians started going out...we brought national health insurance and the only amount you have to pay to get free service is 7.2 Ghana cedis and nobody talked about the 48 Ghana cedis [the maximum amount that the

rich were required to pay] ..., so everybody ended up paying 7.2 Ghana cedis”. Also, many people reportedly refused to enrol into the NHIS at the early stage of the implementation process for partisan reasons - they thought that registering with the scheme would generate support for the party in power at the expense of the opposition party, which they sympathized with. Hence, as Andoh (2013) notes, “the registration was very low in those regions” where the opposition NDC party dominated.

Another factor that adversely affected enrolment into the NHIS is the poor service provision under the policy. Sorsey (2013) explained that,

People with special needs, older people the issue of physical strength to even go through the system - that tedious process of getting your health care service covered by national health insurance. And the fact remains that they are the last people who are seen in the hospitals, they will rather see the cash and carry people and the reason being that the national health insurance authority delay so much in paying providers for national health insurance. If hospitals will be concentrating on national health insurance, they will collapse. It is until recently that we have not heard about them - once a while, I think twice, thrice a year, you see them quarrelling with the National Health Insurance Authority. As I speak now, we are in 2013, I think the latest they got was around December 2012 in terms of payment and so you see hospitals doing a balancing up. If I give you a national health insurance it will take between three to six months for refund. Meanwhile, I am supposed to stock my basic drugs so I need to balance it. So sometimes you see real impediments, disguised impediments on the way of people having national health insurance card but that is how the hospitals also survive

In addition to the above issues, there are frequent reports of shortages of drugs as a result of delays in claims payments to the providers (Awithey, 2013; Mensah, 2013). Many interviewees also complained about finding it difficult to renew their membership as a result of inefficient renewal procedures and methods. For example, as Sorsey (2013) indicates, “somebody heard about the scheme, joins but because of illiteracy, he cannot even determine when his card expires. He goes to the hospital before he realizes that he cannot be given services”. He adds that this is a major “challenge in the rural areas”, where the majority of the population lives (Sorsey, 2013). Despite the above challenges, the NHIS has been sustained. How that was achieved is the focus of the next section.

### **6.3.5. Sustainability**

Right from its inception, the sustainability of the NHIS was questioned. A year into the policy's implementation, for instance, the ILO (2006) issued a report arguing that the generous exemption package under the policy could render the NHIS financially nonviable in the short to medium term. Oxfam's report in 2011 also argued that enrolment of the NHIS was lower than the cumulative value and that the NHIS should be reversed to a NHS system by 2015 as a result (Apoya & Marriott, 2011). A World Bank report projected that the program would go bankrupt by 2013 (Saleh, 2012; Schieber, Cashin, Saleh, & Lavado, 2012). However, it is not only international organisations that predicted the failure of the policy. In her study involving 16 communities in the Central and the Eastern regions of Ghana, Kotoh (2013) noted to her amazement how anxiety about the sustainability of the scheme was present at the grassroots level, particularly among members of the opposition party, NDC. One of her respondents explained why he did not enrol in the scheme: "I thought the NHIS cannot survive any change in government and that it was going to be a 'nine-day wonder' and will die when a new government comes to power" (quoted in Kotoh, 2013, p. 81). In Kotoh (2013), some officers of the scheme recounted how they had also been chased out of certain villages purported to be strongholds of the opposition party. Another big challenge to the policy emerged in the 2008 elections, when the NDC promised to transform the NHIS into a "one time premium" (NDC, 2008, p. 6). Although its precise nature is still unclear, the NDC's plan is generally believed to resemble the NHS system discussed in the Chapter Four of this study.

Nevertheless, the NHIS has been sustained. There are a number of reasons why this has been so. The first factor involves the government's high level of political commitment to the policy over time. For instance, as indicated, the NHIS has been directly linked to the country's poverty reduction strategy (NDPC, 2003). The government has stood by the policy despite the criticism of key international actors, mentioned above. For example, when Oxfam's (2011)

report was released, the NHIA quickly reviewed its processes and, when it found that the report was not completely accurate, issued a rejoinder. The government has also been consistent with its budgetary allocation to the scheme, although this process has recently been challenged by the Ministry of Finance's inability to release the NHIL in a timely manner (Akor, 2013).

The second reason for sustainability is the scheme's ability to create new constituencies, something it does far quicker than expected. The World Bank confirmed this unexpected achievement in a 2012 report:

When the [NHIS] fund was created, earlier estimates (World Bank, 2007) had suggested ...that registration into NHIS would be much lower. However, registration has grown faster than expected, and credit for this goes certainly to the exemption policy to capture the vulnerable population, and to the efforts made by the DMHIS, who being at the district levels, benefit from subsidies for coverage of the exempt groups. They had all the incentives to increase enrollment and increase them fast. However, as registration grew, so did use of health services, and claims (Saleh, 2012, p. 64)

In fact, the above World Bank report not only confirms the high interest the NHIS has generated over the years, but also the design teams' skills in ensuring significant policy change despite the odds. Over time, as indicated above, even key actors, such as the World Bank, labour, GNEHMO and the NDC, that were strongly opposed to the policy have shifted allegiance, becoming the policy's key advocates. For example, a year after Oxfam's report, the World Bank responded. Their report indicated not just their opposition to Oxfam's recommendation, but also that the status quo be maintained. As it notes,

replacing the NHIS with a national health service would not fix the system's problems...the fundamental design features and operational policies of the NHIS share many of the advantages often attributed to a national health service (for example, progressive general revenue funding, coverage of vulnerable groups) and that current policy directions will endow the NHIS with the basic advantages of a formal health insurance model in terms of strategic purchasing and purchaser-provider splits. Refining the structural and operational features of the NHIS to ensure its evolution as an effective public insurance organization is a much more sensible approach than going back to a fully general revenue-funded national health service with free care to all provided through a publically owned and operated delivery system. (Schieber et al., 2012, p. 9).



According to the Bank official interviewed on the subject, the World Bank has also been supportive of the NHIS in financial, technical and logistical terms (Addo, 2013). This argument confirms that external actors have indeed taken over NHIS implementation overtime. In particular, the Bank established a five-year project with the NHIA in order to address some of the key bottlenecks which accompanied the implementation of the NHIS. This includes streamlining the financial and operational management systems by training the NHIC, the DMHISs and the health care providers on efficient financial management (Addo, 2013). The Bank is also helping to improve the claim management system. Indeed, its 2012 report was important inspiration for the policy's 2012 amendment that converted the policy into a unified model and shifted the program from a fee-for-service system to a capitation system of claim payments. These amendments have reduced the bureaucracy involved in the management of the scheme and allowed it to reduce costs (Anane, 2013; Sorsey, 2013). They also "opened a window for the funds to be invested in improving the capacity [of the policy] ... and to invest in any other facilitating program to promote access to health care services as determined by the minister" (Sorsey, 2013). Programmes such as call centres for members to share their grievances to the authorities have also been set up. A programme that seeks to engage a software developer to develop mobile phones that would remind the illiterates to renew their membership has also been proposed (Sorsey, 2013). Another proposal involves allowing rural people to pay their contributions using a "barter" system (Akosa, 2013).

The extent to which the above technical amendments have contributed to the sustenance of the policy over time, however, is in doubt. For example, some respondents indicated that, despite its potential to reduce corruption, the 2012 reform has actually created a higher tendency for moral hazard (Adusei, 2013; Amoh, 2013). As Amoh (2013) states, "until we go back to the district mutual health insurance scheme where we had the boards, representation from the communities at the district level, who were helping in the management of the scheme,

we will never find any viable scheme. And right now the NHIS staff are condoning with the health facilities to dupe the system”. Another respondent confirmed this, claiming that the centralization project has limited the support of local authorities in terms of identifying people that truly deserve to be exempted under the policy (Adusei, 2013). It has also reportedly reduced the “local ownership” character of the policy, making it vulnerable to a possible reversal by opponents on the ground. Also, the suggestion discussed above which would allow rural people to pay their contributions using a “barter” system has not been implemented (Akosa, 2013). Consequently, the renewal rate of registrants continues to be low, leading to lower revenue than expected, as well as significant delays in reimbursing service providers (Nortey, 2013; Sorse, 2013). As well, fraudulent behaviours on the part of officials of the NHIS have persisted despite the collapse of the DMHISs (Amoh, 2013).

Besides the support from the World Bank, a majority of the respondents indicated that what has been keeping the NHIS alive over time is the bi-partisan support it has attained over the years (Akanzige, 2013; Akor, 2013; Kusi, 2013; Sorse, 2013). For instance, as Andoh (2013) notes, “now there is this bi-partisan acceptance to health insurance and that is the strength that we have now”. Asking whether there would be a policy change anytime soon, Niitreb<sup>64</sup> (2013) also responded that, “I don’t see that for now. There were other promises of one time premium [that failed] so it is very difficult to go back, and say that you are undoing all these”. The bi-partisan support for the NHIS is also clear in the parliamentary consensus on the 2012 amendment of the NHIS. Surprisingly, the NDC government, which had not only opposed the NHIS in 2003, when the policy was adopted, but also proposed to change it to a “one-time-premium” system if elected in 2008, proposed the amendment (Andoh, 2013). Also, since the last organized demonstration in 2005, labour and GNEMHO have stopped to openly

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<sup>64</sup> Niitreb is an officer of the WHO in Ghana. He was part of the key actors that were promoting community-based health insurance schemes in Ghana.

oppose the policy. In fact, fear of labour reprisal led to the inability of both sides of the House to change the financial modality in the context of the 2012 reform (Parliament of Ghana, 06/09/2012). As for the members of GNEMHO, “because most of them were without subsidy, they all joined the public system [DMHIS]” (Agyepong, 2013).

Another factor contributing to the sustainability of the NHIS involves the use of annual stakeholder meetings as principal venues to evaluate the policy. These non-partisan meetings have been organized consistently, providing opportunities for opponents and proponents as well as international and domestic actors to contribute to the scheme’s sustainability through dialogue. Indeed, much of the scheme’s success in withstanding pressure from the Oxfam report and the NDC’s one-time premium proposal can be attributed to the annual stakeholder dialogue and the authorities’ ability to incorporate stakeholders’ views and negotiate grievances (Adjei, 2013; Niitreb, 2013).

#### **6.4. Causal Analysis**

In this section, the author shows how various causal factors interacted over time to ensure the transition to NHIS, in spite of obstacles such as political ideology, vested interests, opposition from international actors and the popular assumption that health insurance was impossible in a developing country like Ghana. First, the NHIS was triggered by the crisis of the user fee model, particularly, its adverse impact on access to health care by the marginalised, some of whom had been detained in health facilities as a result of their inability to pay. The depth and gravity of the situation created urgency for change, bringing change agents such as government officials, politicians, researchers, civil society groups and health care experts to the forefront of the search for solutions to the problem. In the process, in the late 1980s, NHIS came on the agenda through the policy entrepreneurship of officials in the MoH and the CBHIS. This interacted with global public opinion so that, while health insurance was in line with both the

social democratic ideology of the government at the time and the fundamental African culture of solidarity and reciprocity, it was held back by the popular assumption that it was impossible given Ghana's socio-economics structure. Although health insurance had gained so much popularity among communities and organisations by 2000, it had not been propelled to the front stage until after the change in government in 2001, when the new government moved the policy process along rapidly. A critical investigation into the matter suggested that the previous government's decision to go slow was shaped not just by the general assumption about health insurance being impossible in Ghana, but also by expert advice that government involvement in health insurance was not advisable mainly because there was little evidence to suggest that the policy could be sustained (Agyepong, 2013). This situation, however, changed after the political transition, as the new government saw an opportunity to introduce SHI not only because it was an election pledge, but also because it was seen as a panacea to the crisis in the health care sector. It was believed it would reduce poverty and contribute to socio-economic development more generally. Hence, in constituting his cabinet, the president made NHIS the main agenda item of his Minister of Health.

Charged with introducing the NHIS, the minister quickly constituted a seven-member design team to work on the technical details of the policy and advice the government on developing a legislative proposal on health insurance. The team's composition and style of work shaped policy direction significantly. Initially, in constituting the team, the minister was influenced by notions of actors who had experience in exploring or implementing health insurance in the country. This situation, unfortunately, led to the total dominance of actors with potentially vested interests in the existing community-based health insurance schemes and a strong belief in the common assumption about health insurance being impossible in the developing world. Thus, the team recommended that the government simply maintain its role as promoter of the existing community-based health insurance schemes rather than changing

them. This situation suggests that, even in the face of a wide window of opportunity, as created by the crisis of the user fee model and the change in government, a path-dependent change may still occur when the change team is dominated by people with significant allegiance to the status quo.

In order to pursue change that departed significantly from the status quo, the government pursued a number of strategies, including reconstituting the design team and bringing in trusted/political associates until the pendulum swung in favour of change. The dominance of the trusted/political associates on the new team made significant change favourable because it was then easier to marginalise opponents and reach consensus regarding the way forward. Hence, unlike the former team, the new team recommended that centrally regulated, district-wide health insurance schemes be instituted alongside the existing private sector based schemes such as PMHISs and PCHISs. Since a similar approach had been unsuccessful in the past, it may be that that recommendation was also shaped by policy legacies. The idea of offering the district-based schemes alongside the private-based schemes was also shaped by the rightist ideology of the government and the strategic choice of the reformers to layer the new policy on the top of existing ones so as to minimise opposition and build consensus for the change. As well, it reflected the manifesto pledge of the government to allow various agents to set up their own health insurance schemes under the regulation of a national body (NPP, 2000).

Other aspects of the policy, such as the NHIF, benefit package, and exemptions, were largely influenced by lesson drawing or translation, as well as policy legacies and political strategies. For instance, the financial modalities under the policy were largely adaptations from the Germany's payroll deduction approach; the UK's tax-based system; and Thailand, Chile, Tunisia and Zimbabwe's premium-based system. However, in place of direct payroll deductions, as in Germany, the design team applied the deductions to the workers' social

security contributions. The team also replaced the general tax system that existed in Britain with an earmarked tax (NHIL) and added a premium that was politically rather than actuarially determined. Much of the content of the exemption scheme and benefit package was drawn from the existing user fee policy, as well as the manifesto pledge and strategy of the reformers to totally abolish user fees.

After the design team completed its work, the draft policy was submitted to the cabinet for initial approval. This stage was also influenced by partisan politics and framing processes. In terms of partisan politics, the increase in VAT was framed as NHIL and the rate was reduced from 3.5% to 2.5%. The reason for this was that the government felt it was politically incorrect to request an increase in a policy that it had opposed so strongly when in the opposition. The framing was a way to conceal the reality of VAT and make it politically attractive before submitting the bill to parliament. Additionally, the existing schemes were layered on the newly proposed schemes in order to cause their demise without directly attacking them. That way, the reformers could limit opposition to the policy.

At the parliamentary level, the approval process was marked by interactions among cognitive factors, institutions, public opinion, vested interests and reformers' strategic choices. For instance, the bill was submitted under a certificate of urgency to be passed into law before parliament went on recess in a week's time. Although that should have created a sense of urgency to such an extent that key parliamentary procedures were discounted, the extent of the influence of the certificate of urgency was limited by certain parliamentary procedures that required a bill of such magnitude to be referred to a committee for detailed study and stakeholder input. This created a window of opportunity for key opponents to veto certain aspects of the bill. For example, it allowed opposition party members on the committee to move the work of the committee beyond the borders of parliament into the regions to conduct further stakeholder consultations and dialogues on the bill, even though this was not part of the

legislative requirements. Labour, GNEMHO, the opposition party, and, somehow, external actors also tried to press their demands, putting pressure on government to find solutions to their concerns. In the process, labour was able to reach a compromise with government to be exempted from premium payment. Concerns raised by GNEMHO, the opposition party, and external actors, however, were rejected.

A critical investigation into the matter revealed that labour's success was shaped more by reformers' strategy of ensuring that there was adequate legitimacy for the passage of the law than institutional influence in the strict sense of the word. For instance, the government could have rejected the requests of labour completely, as it did with GNEMHO, external actors and the opposition party, because they did not wield institutional power to veto the change. However, the government realized that the concerns of labour were credible and also that their support was important in enhancing the legitimacy of the policy. In any case, they also felt that reaching a compromise with labour would promote rather than affect the policy change. Thus, although the stakeholder consultations prolonged the committee's work, they also enabled the committee to build consensus on the bill.

Similarly, the implementation process was shaped by interaction among political strategies, the capacity of the implementation team and policy legacies. For instance, implementation was highly decentralised so that each district established its own scheme and appointed its own board of directors. This facilitated the implementation process and helped build a grassroots constituency for policy change. Also, instead of recruiting experts to implement the policy, the political associates on the design team were charged with overseeing the rollout of the policy. The implementation team, therefore, recruited individuals who would support the policy and ensure a rapid rollout rather than (necessarily) those with expertise in running the policy. Since they lacked the requisite training, a majority of the workers ended up blindly implementing the NHIS; many others, however, engaged in malfeasance and corrupt

practices that affected the policy's sustainability. The strategy of using political associates and moving swiftly with the new policy also helped to mobilise additional support and build significant constituencies for the sustenance of the policy. For instance, within a matter of three years, more than half of the population had enrolled in the scheme, about 88% of whom were already benefiting from it (NHIA, 2009). The positive impact of increased enrolment on the utilization of health care made the policy attractive to international actors, particularly, the World Bank, the ILO and the WHO. These then promoted it across the developing world, sending several countries to study Ghana's situation. Over time, annual stakeholder conferences were also instituted to sort out issues that could significantly affect the fate of the policy.

## **6.5. Theoretical Implications**

The validity of the actor-based institutionalist perspective is once again confirmed in this chapter. It shows how significant policy change may be pursued through the interaction among contextual factors and actors across the various stages of the policy process, including agenda setting, formulation, adoption, implementation and sustainability. While the analysis was performed as though the stages were independent of each other that was only for the sake of convenience and simplicity. In a real world situation, the various stages are interconnected, as issues at one stage of the policy process affect the nature and/or outcome of politics at subsequent stage(s). For example, the urgency at which the Minister of Health was charged with instituting the NHIS had a significant impact on the fast-tracked manner in which it was carried out.

The analysis also reveals how the NHIS was pursued within a context characterised by contextual factors such as the legacy of the user fee model, strong public opinion in support of change and health insurance, institutions, partisan politics and policy ideologies, as well as



vested interests. For instance, the accessibility crisis of the user fee model generated the need for change, which led to the idea of health insurance as a key policy recommendation. Over time, public support for NHIS increased remarkably. However, these factors only really began to matter after the 2001 change in government, which opened a policy window for change and allowed health insurance to move onto the decision agenda. Therefore, confirming Kingdon's (2003) window of opportunity framework, this chapter argues that the combination of the user fee crisis, public support for health insurance and the 2001 political transition created a window of opportunity for the NHIS.

Despite their significance, the above factors did not guarantee the creation of the NHIS. For instance, although the crisis situation was significant at the agenda setting stage, it only made the need for change obvious and did not dictate which change to pursue. This was subsequently pushed onto the agenda by bureaucrats from the MoH. Also, although the 2001 political transition in Ghana was important, it only deepened the urgency for change by bringing a new government to power that had promised to introduce NHIS. However, the government was not bound to introduce NHIS merely because it promised to do so during the 2001 electoral campaign. In fact, the NDC had made, and failed to keep, similar promises in 1992 and 1996. As indicated, the NDC also failed to implement the onetime premium promise after it won the 2008 election. Additionally, members of the first design team, acting under the influence of vested interests and policy ideology or legacy, tried to tilt the policy towards path-dependency until the team was reconstituted in favour of change. Although reconfiguration of the design team facilitated the policy development process, the democratic institutional configuration of the state prolonged the adoption process, at least compared to the adoption of the user fee model, which took place under an authoritarian regime. For instance, besides cabinet approval, the policy was also subjected to the approval of parliament, which widened the potential veto points available to vested interests to oppose change. For example, concerns

raised by labour, the NDC, GNEMHO and external actors generally received critical attention, leading to the various stakeholder discussions and negotiations meant to address their concerns. Such issues ended up delaying the passage of the law longer than expected. Yet, the principle of party-discipline within Ghana's democracy enabled the government to mobilize its members of parliament to vote for the passage of the NHIS.

This discussion supports the analysis that significant policy changes are more difficult to enact in democratic institutions than under authoritarian regimes. However, it fails to support the general assumption that concentrated institutions or institutions with fewer veto points necessarily avert opposing forces on their own. This is because, although Ghana's democratic system still concentrates power in the hands of the government, it could not prevent interests from opposing the NHIS. This is why this study combines the window opportunity thesis with Grindle's (2004) dynamic political process model that recognizes the importance of strategic choice in shaping path-departing policy change despite the odds.

Key strategies employed to facilitate policy change include framing, labelling, layering, translation, negotiation, compensation, accommodation, decentralisation and even inaction, when necessary. For instance, for the sake of legitimacy, even where institutions made it possible to discount opponents' concerns, such as those of the GNEMHO, the NDC and external actors, strategies such as framing remained necessary in order to make the government's decisions appealing. For instance, the NDC's concern that the NHIS would create hardship for the poor was framed as a mere political gimmick that was not in the nation's interest. Additionally, besides the legislative principle of party discipline, which minimized opportunities for members of the main opposition party to build a coalition with members of the other parties, the reformers made a calculated effort to convince the majority in parliament to rubber stamp the policy by skipping key parliamentary procedures they should have been involved in passing the law. Similarly, to ensure a quick rollout of the policy, the authority over

implementation was decentralised to local governments, with strong backing from both the national government and core reformers, particularly the political associates who oversaw the implementation process across the country. A compromise was also reached with labour, while responses to GNEMHO's concerns were framed in a way that appealed to some of their members. Apart from helping to ensure a quick rollout of the policy, the above strategies helped in building constituencies, which, in turn, made the policy more sustainable over time.

Thus, despite the window of opportunity, policy reformers were not and must not be viewed as mere passive objects that just responded to the dictates of the policy environment. That is, their actions were not only motivated by the contextual factors that surrounded them. Rather, the decision to adopt, implement and sustain the NHIS was also conditioned by cognitive, ideational and rational analysis and strategic choices that cannot be strictly reduced to the contextual forces mentioned above. Thus, key actors also shaped the policy environment to either favour or oppose change and determined its outcome. That is why the policy was introduced, formulated and adopted, as well as implemented and sustained, despite the odds.

## **6.6. Conclusion**

The chapter examined the process of transitioning to NHIS in Ghana in the early 2000s, accounting for why and how it occurred despite the countervailing factors. As seen in Table 7, below, while contextual factors, such as the user fee crisis and the change in government, were critical in generating urgency for change, it was largely how they interacted with certain agential factors, such as the policy entrepreneurship of key reformers across the various stages of the policy process, that accounted for the successful transition to NHIS. Thus, while some contextual factors impacted policy change in significant ways, their influence was mediated by policy actors who actually determined the precise direction the policy change would take. The government's main challenge at the time was that many of the key actors, including health

experts, international actors and some government officials whose help was needed, thought that NHIS was unsuitable for a developing country like Ghana, given its large informal sector and poor economic base. Consequently, CBHISes were generally suggested instead. At the formulation stage, this challenge manifested itself in how key ministry officials on the design team tried to tilt the policy towards the status quo. It also manifested itself at the adoption stage through the opposition of the NDC minority, labour unions and international agencies.

**Table 7 Summary of factors leading to the establishment of the NHIS**

<b>Factors</b>	<b>Specifics</b>	<b>Contribution</b>
<b>Conjunctures</b>	<ul style="list-style-type: none"> <li>• Unaffordability of the health care system</li> <li>• Public opinion favoured change</li> <li>• The 2001 election, which led to the power transfer from the NDC to the NPP</li> </ul>	<ul style="list-style-type: none"> <li>• These created windows of opportunity for policy change rather than bringing it about.</li> </ul>
<b>Policy entrepreneurs</b>	<ul style="list-style-type: none"> <li>• The CBHISes and the MoH</li> <li>• The Kufuor government</li> <li>• The seven-member design team</li> <li>• Cabinet and parliamentarians</li> <li>• Implementation team and service providers</li> <li>• The new stakeholders the policy developed overtime</li> </ul>	<ul style="list-style-type: none"> <li>• They seized the open windows not only to propel NHIS onto the agenda, but also to see it through design, adoption, implementation and sustenance.</li> <li>• Different policy entrepreneurs playing different entrepreneurial roles were identified across various stages of the policy process.</li> <li>• What made them unique and relevant for the changes were their leadership, strategies and commitment to change.</li> </ul>
<b>Institutions</b>	<ul style="list-style-type: none"> <li>• Ghana's party-disciplined parliament, with the government having majority of the seats.</li> </ul>	<ul style="list-style-type: none"> <li>• These institutions minimized the veto points available to interests seeking to overturn the NHIS.</li> <li>• They also made it easier for policy entrepreneurs to adopt the policy.</li> </ul>

Fundamentally, the policy was introduced and sustained by reformers or policy entrepreneurs' commitment to the change and their strategies to counteract challenges to that reform. These include reorganization, accommodation, framing, labelling, consultation, layering, inaction, and negotiation, as well as decentralization, the use of stakeholder conferences and other skills and tactics. These strategies were significant in countering international organisation's predictions related to the policy's collapse, among other things. While the contextual factors

were fundamental, they could not have achieved the observed change without the commitment, character and strategies of the policy entrepreneurs at each stage of the policy process.

## CHAPTER SEVEN

### CONCLUSION

#### 7.1. Introduction

The primary goal of this chapter is to discuss the major findings, as well as the policy and research implications of the entire study. As indicated, the study was built on the premise that Ghana has manoeuvred across each of the world's major health policy regimes within just four decades (1957-2003), despite the common wisdom in welfare state literature that radical, path-departing policy changes are rare or that they occur only after long periods of stasis. This study, therefore, sought to explain these profound changes and, particularly, how and why they could have been achieved within such a relatively short timeframe.

In line with the actor-centred institutionalist approach, it was hypothesized that to adequately explain the changes, one must pay close attention to the policy process, including how policies are introduced, formulated, adopted, implemented and sustained, as well as how reformers manage the entire process, seizing the opportunities when they come, creating platforms for changes and dealing with obstacles to reform as they emerge. Given the depth of information and analysis the above research agenda entailed, I employed a research approach that could address these objectives, an enterprise that led me to adopt qualitative case study research methods. The particular qualitative methods employed involved document reviews and semi-structured, in-depth interviews with key actors related to the changes. The interviews were then analysed using the computer-based software, NVivo.

Based on the data analysis, I observed three main contextual and agential factors that mediated across the policy change process to ensure the radical health care changes in Ghana. These factors include the role of conjunctures or windows of opportunity, policy entrepreneurship of key policy actors, and the concentrated institutional configuration of the

Ghanaian state. While all these factors were significant, this study demonstrates that policy entrepreneurs were most important in why and how the changes were achieved.

Contributing to the dynamic or actor-centred institutionalist literature, this study combined insights from various perspectives within this tradition, particularly Kingdon's (2003) "window of opportunity" framework and Grindle's (2004) "dynamic political process" model to explain the changes. In relation to Kingdon's (2003) work in particular, this investigation showed how certain contextual changes, such as the crisis of the health care system, created windows of opportunity that were seized by key policy entrepreneurs before path-departing policy changes occurred. Relative to Grindle (2004), on the other hand, this study demonstrated the extent to which the policy changes faced strong obstacles that were surmounted through the commitment, leaderships and strategic choices of the policy entrepreneurs behind the policies.

In addition to revealing new ways by which policy entrepreneurs may pursue path-departing policy change, this study also confirmed many of the findings of the existing literature with respect to the process and strategies of path-departing policy change. From an institutionalist standpoint it also revealed the extent to which the concentrated institutional configuration of a state may facilitate the adoption of a path-departing policy change, and limit but not necessarily crowd out interests, which may utilize other avenues to oppose change. Finally, this study found that, while policy entrepreneurs may be effective in achieving path-departing policy change, the strategic behaviours of these policy entrepreneurs could have adverse ramifications in terms of fuelling the momentum for policy reversal within a short period of a policy's establishment.

In the following sections, a more detailed summary of the findings is provided. The next section discusses the policy changes explored in this study. Subsequently, the key findings with respect to why and how the path-departing changes occurred within the timeframe in

which they did despite the observed countervailing factors are addressed. The next section focuses on this study's contribution to the existing literature on policy change in light of its key findings. Then, the core lessons that could be drawn from the study's findings and their implications for public policy practice are highlighted. A discussion of the limitations of the study and its implications for future research is featured in the subsequent section, which leads to concluding remarks about the entire study.

## **7.2. A Review of the Changes**

As indicated, the changes analysed in this study of Ghana's health care system involve the establishment of a NHS-type system (with first dollar coverage) in the 1960s, the introduction of user fees in the 1980s, and the adoption of NHIS in the early 2000s. Before examining the causal factors underlying the changes, it was deemed worthwhile to first and foremost examine the nature, character and magnitude of the changes so as to conceptualise what needed to be explained and why explaining them was necessary. Based on the criteria of spending and institutional changes, all three reforms were identified as path-departing in nature. For instance, public spending on health care for the population, including the marginalised, was found to have increased tremendously after the establishment of the NHS. Also, although nominal public spending on health care rose after the introduction of user fees in the 1980s, real public expenditure on health care was inadequate, resulting in much of the burden of health care falling on individuals and households, a significant majority of whom exited the public health care system as a result. With the adoption of NHIS in the early 2000s, public health care spending has not only increased, but a significant portion (about 70%) of the cost of health care has also been taken away from individuals and households.

Besides the changes in public spending, changes in the institutionalisation of health care occurred with each shift in the health policy regime. For instance, the NHS system resulted



in a shift from a health care system that targeted the few Europeans in the country during the colonial period to one that made access to health care a universal right of all residents of Ghana, including foreigners. Having been significantly curtailed under the user fee model, the principle of universalism has been significantly restored under the NHIS. For example, through the mechanisms of prepayment, risk-pooling and cross-subsidisation, the NHIS provides a large exemption package for the majority of the marginalised, including children, the aged, pensioners, pregnant women and nursing mothers. By making a minimum contribution of between 7 cedis and 48 cedis per annum, the rest of the population is also covered for 95% of all diseases in the country. Hence, as indicated, public satisfaction in the health care system improved markedly after the introduction of the NHIS when compared to the satisfaction level under the user fee model.

Despite their importance, however, none of these changes appeared to have taken the shape of the sudden and wholesale variety emphasized by the punctuated equilibrium thesis. This is because these policy changes occurred over a period of time and because some remnants of past regimes were carried forward onto the new regimes, a situation that also suggests that the path-dependency thesis may be hard to completely debunk even in circumstances of radical policy changes.

### **7.3. Examining the Causal Factors Underlying the Policy Changes**

As summarised in the table below, a cross-regime analysis revealed that three main contextual and agential factors were fundamental to accomplishing the changes in Ghanaian health policy after independence. These factors include the role of (a) conjunctural factors in creating windows of opportunity for the changes; (b) policy entrepreneurs in propelling the changes onto the political agenda and championing the changes through the design, adoption, implementation and sustenance of the policy over time; and (c) the concentrated institutional

configurations of the Ghanaian state, which both minimised the veto points for vested interests and allowed the policy entrepreneurs to pursue the adoption of the proposed changes. However, while all of the above factors were crucial for explaining the policy changes, the study observed that policy entrepreneurs' commitments and strategies were key in why and how the changes occurred.

**Table 8 Summary of the factors underpinning the health care changes in Ghana**

Factors	Specifics	Contribution
Conjunctures	<ul style="list-style-type: none"> <li>• The nature of the economy</li> <li>• The nature of the health care system</li> <li>• Change of government</li> <li>• The nature of the international environment</li> </ul>	<ul style="list-style-type: none"> <li>• They created windows of opportunity for the changes rather than determined the policy changes.</li> </ul>
Policy entrepreneurs	<ul style="list-style-type: none"> <li>• Proposal actors</li> <li>• The government in power</li> <li>• The design team</li> <li>• The actors for adoption, including cabinet and parliamentarians</li> <li>• The implementers, including service providers</li> <li>• The new stakeholders of the changes</li> </ul>	<ul style="list-style-type: none"> <li>• They seized the open windows to institute the changes across various stages of the policy process.</li> <li>• Different policy entrepreneurs playing different entrepreneurial roles were identified across various stages of the policy process.</li> <li>• What made them unique and relevant for the changes was their leadership, strategies and commitment to change.</li> </ul>
Institutions	<ul style="list-style-type: none"> <li>• The unitary state of Ghana</li> <li>• The party-disciplined parliament of Ghana</li> <li>• The military system with no parliament</li> </ul>	<ul style="list-style-type: none"> <li>• These concentrated institutions minimized veto points for interests to overturn the policies.</li> <li>• They also made it easier for the policy entrepreneurs to adopt the new policies.</li> </ul>

### 7.3.1 Conjunctures and Windows of Opportunity

In his seminal study on agenda-setting, Kingdon (2003) coined the concept of “window of opportunity” to refer to those circumstances in which policy entrepreneurs obtain the leeway necessary to push through their favourite policy ideas for reform. In line with Kingdon (2003), this study found that, across all the three cases of major health care change studied, conjunctural factors related to the nature of the economy, the existing health care system and the political situation in Ghana created windows of opportunity for the changes to occur. The establishment of the NHS system, for instance, emanated from the open window created by the interaction of conjunctural factors, including the existing discriminatory and exorbitant health care system,

the 1960s economic boom, the attainment of political independence and republican status around the same period, the election into office of a socialist and nationalist leader in the person of Kwame Nkrumah and the global trend towards broad welfare state regimes. The creation of the user fee model was also triggered by the interaction among various factors, such as the economic bust of the 1980s and its effects on the health care system, the political transition in 1982, the failure of earlier populist measures, efforts to solicit help from the Eastern Bloc and the expulsion in 1983 of Ghanaians living illegally in Nigeria. Later on, the accessibility challenges of the user fee model coupled with the 2001 election of a government that had campaigned on the promise of replacing user fees with a health insurance programme created the window of opportunity for the adoption of NHIS. The significance of the above factors was that they created the sense of urgency necessary to pursue the major changes to the health care system.

### **7.3.2 Policy entrepreneurship**

As important as they are on their own, these open windows have to be seized by someone - key policy actors - before they can fully impact the process of policy change. In short, the mere existence of policy windows does not guarantee that certain policy changes will occur (Cortell & Peterson 1999; Kingdon, 2003; France & Taroni, 2005). Kingdon (2003) refers to these actors as policy entrepreneurs. According to Kingdon (2003), policy entrepreneurs are made up of “people who are willing to invest in pushing their pet proposals or problems, are responsible for prompting important people to pay attention, but also for coupling both problems and solutions and both to politics” (p. 20). Based on Kingdon’s analysis, this study observed the entrepreneurship roles of key political and bureaucratic actors such as officials of the Maude Commissions, the GMA and PSoG, the MoH and the CBHISes, as well as the World

Bank and the IMF played by pushing the path-departing changes onto the governmental agenda.

However, because of its “garbage can”<sup>65</sup> undertone, as well as its disproportionate focus on agenda setting, Kingdon’s (2003) “window of opportunity” framework fails to provide enough analytical leverage with respect to policymaking beyond the agenda setting stage. Grindle’s (2004) “policy as political process” model complements Kingdon’s (2003) framework. In her study, which focused on policy change in Latin America, Grindle (2004) explains that path-departing change may still occur even in the absence of window of opportunity or despite obstacles to reform such as opposition from vested interests and institutional friction. To explain path-departing change, she suggested that scholars must examine the entire policy process to properly capture the extent of the challenges involved in path-departing policy change and how they are surmounted through the strategic choices of reformers at various stages of the policy process. Combining the frameworks of these two scholars, this study also noted that even when there are windows of opportunity, pursuing path-departing policy change could be a difficult task, especially when post-agenda setting developments are critically considered.

For instance, medical doctors and provider facilities seriously resisted the adoption of the NHS (Coleman, 1997; Arhinful, 2003). In the 1980s, the general public, the labour unions, some forces in the army and key members of the PNDC held public protests and press conferences, and even launched coup d’état attempts, to prevent the implementation of the user fee policy (Hutchful, 2002). The NHIS, however, appeared to have faced the most difficulties. Beyond opposition from interest groups (labour, GNEMHO) and the main opposition political party (NDC), international actors that are generally touted as the prime movers of policy reform

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<sup>65</sup> The theoretical assumption that decisions are not made through carefully calculated processes but as a result of chances, which are created when two or more independently operating factors accidentally converge at a conducive point such as in a garbage can.

in LICs, including in post-independence Ghana (Neuman, 1998; Grindle, 2000; Selin & Linnér, 2005), were also vehemently opposed to its introduction (Rajkotia, 2007; Agyepong & Adjei, 2008; Coleman, 2011). As Seddoh and Akor (2012) note, some international actors even decided to march on parliament to protest the passage of the NHIS law. Others also wrote letters to the president, asking him to fire the Minister of Health for pursuing the policy, while still others went to the extent of sponsoring certain national vested interests to overturn the policy (Rajkotia, 2007).

But even beyond opposition from vested interests and global actors, most of the changes went against the ideology of the government in power, which posed further challenges. For instance, PNDC members, the majority of whom were strong leftists, had to be moved along by the reformers before the user fee policy could be successfully implemented (Arhinful, 2003). With its ideological affinity with the status quo (i.e., the user fee model), the rightist NPP also had difficulties in dismantling the user fee policy and replacing it with a solidaristic NHIS. The ideological conflict embedded in such decision is clear in the response given by PNDC's members when user fees were first proposed by the MoH, as well as from the speech of the minister of health during the introduction of the NHIS. As indicated, the PNDC saw the MoH's user fee proposal as politically unwise since it could have infuriated the support base of the party (Adibo, 2013). On the floor of parliament, the minister of health during the Kufour administration also indicated that introducing a NHIS is "any socialist's dream. But it took the Government of President Agyekum Kufuor to set this in motion" (Parliament of Ghana, 2003, p. 167).

Finally, when compared to changes taking place in the developed world, the policy changes in the developing world tend to face extreme financial difficulties as a result of their limited financial bases. This was evident during the implementation of the NHS system after 1964. A similar situation occurred during the user fee regime, as a result of the failure to

increase fee levels over time. It also occurred under the NHIS because of neglect by international agencies, which had been a reliable source of revenue for the health sector since the 1980s.

Confronted with challenges like these, Pierson (1996) argues that politicians would shun path-departing policy change. Based on Pierson's (1996) analysis, the governments of Ghana should have been expected to retreat from pursuing the changes underlying this study. The two occasions (1968 and 1969) on which Ghana's NLC military regime withdrew its user fee proposals in the face of public resistance (Arhinful, 2003) reinforce this expectation. Yet, despite the above challenges, the governments in charge of the three major episodes of health care change never retreated from their initial decision to profoundly reform the health care system. For instance, despite economic challenges, the Nkrumah government introduced surcharges on imported goods to generate additional revenue rather than introduce user fees or dismantle the NHS system (Arhinful, 2003). Also, despite the numerous coup attempts against him, as well as the press conferences meant to dissuade him from introducing the user fee policy, and even members of his own political party's opposition, Rawlings never retreated from pursuing the user fee policy. In reality, in spite of opposition from the public, vested interests such as labour unions and the World Bank and IMF, the Kufuor NPP administration went ahead with its NHIS proposal. In fact, beyond making it the main objective of his Minister of Health, as indicated in the preceding chapter, President Kufuor also made the NHIS a substantive part of the country's growth and poverty reduction strategy (Seddoh & Akor, 2012). During the interviews, the minister in charge of the NHIS' introduction recounted the critical role president Kufuor's leadership and commitment to the change played. Hence, as he argued, "as far as health insurance is concerned, all credits go to him [President Kufuor]" (Afriyie, 2013). In line with Grindle (2004), therefore, this study noted that additional policy entrepreneurship, including strong political leadership, commitment and strategic choices on

the part of the governments in power, were crucially important to the success of path-departing policy changes.

Yet, even when they are combined with the policy window argument above, the political commitment and leadership of the governments alone cannot fully explain why and how the health care changes in question occurred. For example, Coleman (2011, p. 20) indicated how the NDC government put “immense pressure” on the MoH in 1995 to institute a health insurance policy, but in vain. Also, as seen in Chapter Six, it became clear how the first design team of the NHIS suggested the maintenance of the status quo, despite the NPP government’s clear commitment for bold change.

Regarding the analysis of the three major policy changes considered in this study, it is clear political leadership and the governments’ commitment and strategies had to be buttressed with the policy entrepreneurship and effective policy commitment and strategies of the design team and all those involved in the adoption, implementation and sustenance of the policy changes. For instance, the design teams played a fundamental role in determining the content of the policies and in managing conflicts their decisions created before the policies were submitted for adoption. Besides the design teams, key actors at the cabinet and parliamentary levels oversaw the policies’ adoption, while service providers and specially established teams championed their implementation. In addition to the commitments and strategic choices of the governments in power, the vested interests or stakeholders the policies generated contributed immensely in sustaining the changes over time.

Also, echoing Grindle (2004), this study found that the strategic choices of policy entrepreneurs were the fundamental reasons why and how the changes occurred despite the countervailing factors. These strategic choices are in different forms. Nevertheless, they may be broadly classified into two main categories – soft and hard. The soft strategies include the use of compensations (financial remuneration and other rewards), ideational processes

(framing, public education, consultations, and negotiations and compromises), underground mechanisms (layering, drift and translation) and others tactics (incremental vs. rapid scale out of policy, use of narrow vs. broad design teams or political associates, decentralising power of implementation, accommodation of diverse interests in the policy and strategic timing of reforms). Hard strategies involve the use of repressive mechanisms (brutality, arrests, detainment, ban of political groupings and media censorships).

Hard strategies were often employed by undemocratic regimes, while the soft strategies were mostly used by democratic regimes. For instance, having employed compensation at the initial stages of introducing the NHS system, when his regime was democratic, President Nkrumah switched largely to hard, repressive strategies like media censorship and detention to quell opponents after 1964, when he had turned himself into a dictator (Kraus, 1979). Because it occurred during a stable democracy, the policy entrepreneurs of the NHIS essentially abstained from using hard strategies to pursue change. Also, while repression was the main strategy of the PNDC military regime during the transition to user fees in the 1980s, it was less used in the 1990s, after the PNDC had converted into a democratic party (NDC). Rather than repression, the NDC increasingly utilized soft strategies to fend off opposition. Democratic regimes often used compensation, for example, mostly in the face of labour resistance. For instance, as indicated above, the Nkrumah's democratic government compensated mission hospitals and medical officers with annual allowances in order to secure their consent to introduce the NHS system. A similar reality occurred during the transition to NHIS and the user fee model.

Underground approaches were employed in situations where changes needed to be made without necessarily attacking the existing policy. These changes were, therefore, indirect or incremental in nature. For instance, by quickly layering the NHIS onto the existing private insurance systems, almost all of these private schemes silently disappeared. By refusing to



increase the user fees after 1985 despite a changing context (i.e., policy drift), the fees were increased nevertheless, through the actions of the various service providers, with no direct intervention from reformers. Opposition could be prevented by using these underground approaches. However, reformers also used these approaches when ideological conflicts prevailed, such as during the transition to user fees, and the one to NHIS.

Furthermore, ideational strategies such as public education and consultations were often employed to explain reforms' content to the public, particularly where opposition to the reform appeared to derive largely from public misunderstanding. For example, the Minister of Health and Dr. Adibo went on national television and radio to educate the public on the user fee policy before its implementation, in order to address potential grievances and build consensus for the policy.

Ideational frames were also utilised to legitimate certain policy choices and appease potential detractors. For example, the tax (VAT) component of the NHIS was framed as NHIL, which the reformers depicted as different from the former, although my interviews with them showed that they were known to be the same. Ideational frames were also employed to solidify decisions that had been reached through other strategies. For instance, policy entrepreneurs went beyond the compensation offered to labour to persuasively and consistently frame the NHIS as favourable to workers since it would protect them so they could enjoy the full benefits of their pension funds (Amoh, 2013). In fact, some of the reformers even cited Ghanaians' average life expectancy at birth to justify their claims about how better health care could help more people enjoy their old-age pensions (Parliament of Ghana, 2003).

In addition, ideational frames were employed to defuse the potential for ideological conflicts. For examples, by using terms such as obnoxious, inhumane, iniquitous and barbaric, the policy entrepreneurs described the user fees as unacceptable, meaning that the government had to push for health insurance despite it being at odds with the ideology of the regime

(Parliament of Ghana, 2003). Key members of cabinet also framed the NHIS as being in line with the NPP's political ideology. As the Minister for Finance and Economic Planning, Mr. Yaw Osafo-Marfo, indicated, "we can only talk about the whole philosophy [behind the policy]... We are descendants of Professor Kofi Abrefa Busia [a forefather of the NPP] and we believe in each of us becoming each other's keeper. You can become each other's keeper when you go for a health insurance scheme" (Parliament of Ghana, 2003, pp. 160 -161).

The policy entrepreneurs also employed policy learning and lesson-drawing. This occurred, mostly, in situations where specific foreign models and/or existing policy ideas were perceived as potentially relevant for addressing the health care situations at hand. For example, the policy entrepreneurs drew lessons from the content of the British NHS system, the colonial user fee model, and Germany's SHI system. However, foreign and existing ideas were adapted to suit the prevailing context of the new policy.

Other approaches used to divert opponents' attention and to speed up the pace of the reform include strategic timing and decentralization. For instance, the PNDC government timed its announcement of the user fee policy during the 1983 budget, which distracted opponents from attacking the user fees *per se*. Beside the diversion, in the face of opposition by external actors, the reformers under the NHIS cut out their official and unofficial relationships with them (Coleman, 2011). NHIS implementation was also decentralised in order to ensure a quick rollout of the policy and build new constituencies in support of its sustainability.

### **7.3.3 The Concentrated Institutional Configuration of Ghana**

It must be emphasised, however, that reformers did not always face strong challenges. In the course of their work, particularly during the process of adoption, the policy entrepreneurs were almost always favoured by the concentrated institutional configuration of the state, which

limited the number and extent of the veto points available to interests opposed to the proposed policy changes. For instance, the user fee policy of the 1980s was approved by a military government, while the NHS and NHIS systems were approved under democratic institutional configurations with a unitary system of government and a unicameral legislature that enforced party discipline. For example, with the principle of party discipline in place, both the Nkrumah and Kufuor governments were able to compel their respective party members, who were the majority in the legislature, to support their respective agendas. In fact, had they gotten the majority of the seats in the legislature, the opposition NDC would definitely have voted to overturn the NHIS, instead of staging a walk-out, as it did. Because of this, I argue that the institutional configuration of the state was a major factor that facilitated the adoption of the changes in Ghanaian health policy over time.

However, as indicated, this story must not be viewed as though the institutional configurations were solely responsible for the policy changes adopted. There were also weak policy legacies in the sense that, in Ghana, existing policies were not strongly entrenched, and vested interests were not as powerful as those of advanced industrialized countries, which meant they could not prevent change. Besides, using various strategies, the policy entrepreneurs were determined to cause change even where institutional and societal obstacles to change were strong. With respect to the user fee policy, for instance, reformers had to reduce fee levels in order to make them quite affordable and to limit opposition from key forces within the society such as labour (Waddington & Enyimayew, 1990). Similarly, the NHIS bill was submitted to parliament under a letter of emergency, which was timed five days before parliament would go on recess. That strategy expedited the adoption process, as it created a sense of urgency, which, in turn, limited debate and deliberations on the bill. But, although the parliamentary majority exerted a lot of power, opposition members as well as other opponents of the bill, such as labour unions, managed to delay adoption beyond the five-day period by

using the media and other strategies. In the face of the increased opposition to the NHIS bill and misinformation about it, both the design team and the parliamentary select committee on the NHIS bill decided to hold consultative meetings across the country to clarify key issues with the public before resuming the adoption process at a later date. Thus, while the institutional configurations of Ghanaian politics did help to bring about health policy change, this should be considered in conjunction with the analysis of the reformers' strategies and commitment to reform. In other words, institutions do not explain everything on their own.

While they were helpful in pursuing change, most of the above strategies ended up generating severe sustainability challenges, which, in turn, often fuelled momentum for further change further down the road. For instance, by 1964, Nkrumah's socialist policies, including the recently-created NHS system, were already facing a funding crisis (Senah, 2001). By 1968, a movement for dismantling the NHS system had already captured the decision agenda, leading to the enactment of the 1969 NLC user fee legislation (Arhinful, 2003). Although the poor state of the economy at the time had been reported as the main factor behind this funding crisis of the NHS (Senah, 2001), the impact of the compensations offered to medical doctors and facilities also made a difference. Having been implemented under pressure in the mid-1980s, the user fee policy also generated remarkable policy challenges in less than a year's time, a situation directly related to reformers' strategies (Waddington & Enyimayew, 1990, 1989). For instance, the health care staff utilised the opportunity created by policy drift (the government's lackadaisical attitude towards changing fees to reflect inflation and other contextual changes) to not only create artificial drug shortages, but also to set their own fees and extort bribes from patients. This situation aggravated the unaffordability of the user fee model and accelerated the need for further policy change (Nyonator & Kutzin, 1999). By 1986, for instance, the PNDC's Minister of Health had already announced steps to replace the recently-adopted user fee policy (Coleman, 2011).

After being implemented nationwide in 2005, the NHIS had also generated a strong movement for its rollback in 2006, mainly because of the challenges posed by the strategies reformers used during the policy's formation (ILO, 2006; Rajkotia, 2007; Apoya & Marriott, 2011; World Bank, 2012). Policymakers discussed how to address the challenges these strategies posed, especially with respect to the compensation offered to labour. As indicated above, the current NDC government proposed steps to replace the NHIS with a one-time premium system right from 2008. The 2011 Oxfam report also backed this change, arguing for its replacement with a NHS system in the shortest possible time (Apoya & Marriott, 2011). However, no concrete action has yet been taken because of the fear of labour reprisal (Parliament of Ghana, 2012). Given that all the health policy transitions had been instigated, one way or the other, by negative feedback from the strategies employed before and during the reform process, this study suggests that these feedbacks must be considered when explaining why and how radical health policy changes occurred within a relatively short time frame.

#### **7.4. The Contribution of the Study to the Existing Literature on Policy Change.**

This study contributes to the dynamic or actor-centred institutionalist literature by showing how insights from various perspectives within it, particularly Kingdon's (2003) window of opportunity thesis, Grindle's (2004) "dynamic political process" or design team perspective, Hacker's (2004) concept of policy drift, Thelen's (2005) concept of layering and Campbell's (2004) concept of translation, as well as the scholarship on ideational frames (Blyth, 2002; Campbell, 2004; Béland, 2010), can be combined to better explain the radical policy changes in an unusually short period of time. For instance, as argued, contextual factors such as the state of the Ghanaian economy, the crisis of the health system and changes in government interlaced to create windows of opportunity for change. The open windows were then seized by policy entrepreneurs such as the governments in power, which set up design teams to

develop policy initiatives for action. In the process of their work, the reformers encountered opportunities like Ghana's concentrated institutional configurations, but also challenges that required political leadership, great strategies and commitments. Some of the strategies employed were compensations, strategic timing, drift, layering, translation, framing, decentralization, accommodation, negotiations and compromises, as well as consultation and public education. This study discusses additional policy change strategies involving the use of brutality, suspension, media censorship, co-optation of labour, the banning of opposition groupings and the colonisation of reform teams by political associates of the regime in power. However, these repressive strategies were often employed as a last resort and mostly by undemocratic governments. Another related contribution of this study to the dynamic institutionalist literature is that, besides being a medium for change, political strategies may create unsustainability challenges if they are not employed with caution. Compensations, for instance, could lock-in policymakers, as it is usually difficult to withdraw compensation even in moments of obvious unsustainability. These adverse effects could drive the momentum for further changes within a relatively short time frame. But, as indicated above, framing may be a cheaper and more effective option compared to compensation in bringing about more lasting policy change.

This study also suggests some modifications to some conventional wisdom in the welfare state literature. The first involves the theory of path dependency. As indicated, the path-dependency literature suggests that factors such as institutional friction, policy legacies, vested interests and the fear politicians have of losing elections in the face of unpopular policies would create policy stasis (Pierson, 1996). To some extent, my study observed the influence of the above factors. For instance, the legacy of the PNP's user fee proposal in 1982 shaped the PNDC's in 1983/1985. The existing community based health insurance systems also influenced the model that Ghana adopted for its NHIS. Vested interests such as labour unions and medical

doctors and facilities also protested widely in an attempt to quash the changes. As indicated, some of these groups even attempted to oust the PNDC through a coup d'état because of its market-based policies, including user fees. All these factors should have encouraged the governments in power to back out on their policy change agenda. The fact that the NLC withdrew its user fee proposal should make us understand, indeed, that the path-dependency thesis is tenable. However, this study suggests that the path-dependency thesis may be incomplete unless it accounts for additional factors, including political commitment and strategies. In the face of low commitments to reform and a lack of effective strategies, policy change initiatives may fail, leading to path dependency. But when a high level of political commitment is backed by effective strategies, not only could path-departing policy changes occur, but also they could occur within an unusually short period of time.

Another important approach that may need revision in light of this study is the interest-based perspective. This perspective argues that policy change is shaped by interest groups. According to this view, radical policy change may occur, but it must be supported by key vested interests. With respect to the reforms under consideration in this study, it was found that, indeed, interests shaped the observed outcome. For instance, they delayed the passage of the NHIS. Labour also managed to secure an exemption category in the law. With respect to the NHS, medical doctors also managed to secure some allowances. However, the contribution of vested interests to the overall reforms was minimal. In the case of user fees, direct influence of outside interests was imperceptible. In the case of the transitions to NHS system and to NHIS, compensations and framing were able to convince reluctant interest groups to support change, a situation that suggests the need to consider interests as malleable, to a certain extent.

The partisanship perspective should also be modified in light of this study. Regarding partisanship, the general assumption in the welfare state literature is that left-wing parties build broad-based and redistributive health systems, while right-wing parties construct limited social

policies (Hick, 2011). This assumption is confirmed by the introduction of the NHS system, but not so much by the cases of the user fees and the NHIS. When dealing with partisanship in analyses of policy change, there may be a need to consider a modified perspective. While partisan ideology may appear as an important factor in policy change, it is not always the case. In the face of economic crisis, right-wing governments may pursue retrenchment; in the face of severe market failure, these governments may also pursue broad-based, redistributive policies despite internal opposition. In order not to lose support from their base, however, such decisions must be buttressed by framing processes, so as to make ideological U-turns seem more acceptable.

Finally, the common wisdom within the globalisation literature is that the South follows the policy recipes of the North, which also uses its disproportionate political, economic and technical power to impose policy ideas on the Global South (Grindle, 2000; Selin & Linnér, 2005). This view should be modified. Of course this perspective has a basis in the reforms under study. For instance, as indicated, a British citizen headed the commission that recommended the establishment of the NHS system. Also, Dr. David Bradchott, an Israeli citizen, designed the policy (Arhinful 2003; Coleman, 2011). In addition, as indicated above, the World Bank and the IMF pushed the user fee policy onto the agenda. Yet, at the same time, the involvement of the above actors was largely locally driven, rather than imposed. Also, international actors failed in their fervent resistance of the NHIS (Coleman, 2011). Thus, while it acknowledges the globalisation thesis, this study suggests that scholars within this tradition should broaden their perspective and consider factors that make global actors more or less influential in the developing world. In doing this, they should include domestic policymakers' perceptions of the status quo and whether or not they could find credible solutions internally to address their own problems. In the 1960s, when external actors were involved, it was largely because domestic expertise on health care policy was inadequate, as discrimination under



colonialism did not encourage its emergence (Baidoo, 2009). Reliance on traditional medicine may have also prevented domestic actors from seeking training in allopathic medical care. Yet even external input into the reform, as indicated, was solicited domestically rather than imposed from abroad. In the 1980s, the poor state of the Ghanaian economy also warranted help from outside, but not necessarily to introduce user fees. In fact, the idea to introduce a user fee policy had been proposed long before the IMF and World Bank made it a loan conditionality for Ghana.

International actors could not influence the NHIS because some domestic experiments in the communities had shown positive results. Therefore, the domestic policy entrepreneurs had concrete evidence to support their reform plan, despite international opposition. The principles of health insurance could also sync with certain local practices, so people could easily relate with it. Indeed, as indicated, the negative effects of user fees had reached appalling levels. Above all, the new government had promised to create the NHIS in the election campaign; failure to comply was perceived as being potentially disastrous for the government in subsequent elections. All these factors combined to encourage the government to reject the influence of global actors. Overall, this study suggests that the North-South interactions during policy change must move beyond the emphasis on the logic of external imposition to account for the domestic situations that make global support desirable rather than compulsory.

## **7.5. Implications for Public Policy Practice**

The above findings provide crucial lessons for improving the practice of public policy. Much of the existing literature grounded in the path dependency perspective has created the false impression that it is always true that “institutions...condition political change...by empowering the beneficiaries of established arrangements, creating obstacles for challengers, and limiting the options for innovation” (Weyland, 2008, p. 282); or that it is unavoidable that “inefficient

institutions and technologies will persist, blocking or retarding social change” (Rico & Costa-Font, 2005, p. 233). On the contrary, this study allows policymakers to understand that, even in the midst of the supposedly “sticky factors”, such as vested interests, ideological conflicts and opposition from global forces, no system is impossible to reform; significant policy changes that could ensure drastic improvements in health services can be achieved when, among other things, the requisite commitments and strategies are employed. In this regard, this study charges policymakers by viewing policy change as a dynamic rather than sticky political process where the strategies and commitments of policy actors matter significantly.

At the same time, however, the findings of the study suggests that uncritical employment of political strategies could create major problems that could lead to further momentum for changes aimed at reversing the newly-established policy order. For example, as argued, compensation could create perpetual lock-in for reformers and significant costs for policy makers. Particularly, in the circumstances where opponents were compensated, such as in the creation of the NHS system and the NHIS (in the forms of annual allowances or free enrolment, respectively), it often became difficult for policymakers to disentangle themselves from those webs of interests, even when the available evidence supported the need to do so. However, where framing was employed, such as during the implementation of the NHIS, there was no further costs associated with this strategy, except that it might have involved more thinking and required greater political acumen. Particularly, as the process of introducing the user fee model made clear, an uncritical employment of drift or layering could also lead to a disproportionate rate of underground dealings and their attendant effects, such as artificial raises in fee levels and high costs of health care to patients. In addition, whereas repression was effective in dealing with opponents of change, it led a majority of the people to exit the public medical system rather than voicing their opposition to policy change. By adopting the “exit option” (Hirschman, 1970), most of these people chose to stay home with their diseases or to

resort to the unregulated informal health sector, which was dangerous for them. Hence, strategic choices aimed at bringing about policy change must be made with a high degree of caution, as their effects could prove costly over time.

## **7.6. The Limitations of the Study and Their Implications for Future Research.**

To be able to shape future research on policy change, specifically in the developing world and SSA, it is crucial to acknowledge the following limitations of the present thesis. The first limitation relates to the scope and context of the study. Particularly, this study focuses on health policy change in only one country, Ghana, which represents only a fraction of the many countries in the developing world. As “the beacon” for Africa (World Bank, 1993, p. ix) and the first SSA country to gain independence, Ghana undoubtedly holds a special symbolic place in Africa. Yet it is crucial to note that, in many significant ways, Ghana does not represent Africa, let alone the entire developing world. In SSA much like in the developing world in general, society is very complex and cross-country differences abound, in terms of economic, social and political factors. Hence, extending the scope of the study beyond Ghana would be helpful to better understand the conditions under which radical policy change takes place in the developing world.

Second, beyond extending the scope of the analysis of policy change in general to other jurisdictions, future studies might also compare the health policies of multiple countries in order to compare findings. Besides comparing cases within the developing world, studies that compare cases across the developing and the developed worlds may yield additional insights to shape the analysis of health care change and, possibly, concretize the findings of this study.

Also, since the theoretical underpinnings of the study focus on the welfare state in general and not just on health care, which is only one part of the welfare state, it may be crucial

that future studies also focus on other policy areas to both ascertain and compare findings about the sources of policy change in LICs.

Additionally, as indicted in chapter 3, none of the people who directly participated in the development of the NHS system was still alive at the time the study was conducted to directly inform it. Although this problem was rectified through the review of numerous written documents on the subject and through interviewing people who were abreast with the politics at the time and/or witnessed the policy's implementation, it would still have been enriching to interview those people who directly participated in the reform. Hence, the chapter on the NHS is quite limited in terms of the richness of the data employed. Subsequent studies may provide additional enrichment to the discussion on policy change by considering, at least, memos and minutes of discussions leading to the establishment of the NHS system.

Although the findings regarding the impact of global actors on policy change are relevant for future studies, they are inadequate for making definite conclusions about this issue. A deeper study on the role of external actors, using the health care sector and/or other policy areas, may help to further test conventional wisdom regarding the disproportionate impact of global actors on policy change in the developing world. In a similar manner, the discussion on the effects of political strategies remains purely qualitative. Thus, in the future, studies might also consider estimating, in financial or quantitative terms, how much political strategies might cost the health care system. Such studies would also be helpful in getting a better understanding of the role of political strategies in policy change.

## **7.7. Concluding Remarks**

This chapter has paid critical attention to the key underpinnings of this study, which involved explaining why and how Ghana could pursue the radical changes in health policy within an unusually short timeframe and despite certain countervailing factors. Our analysis revealed not

only that the mainstream understanding of policy change emphasising path-dependency is problematic here, but also that no one factor can adequately account for the occurrence of the health policy changes Ghana has witnessed since independence. In explaining these changes, the study argued that that we should pay particular attention to the interactive role key contextual and agential factors across the policy process play, such as the role of windows of opportunity, policy entrepreneurship by key policy actors and the concentrated institutional configurations of the state that facilitated the adoption of the changes. These findings provide a relevant framework for understanding policy change in the developing world, where radical policy change appears as relatively common. They also provide important lessons and strategies that policymakers in general can employ in their efforts to pursue policy change and improvements to their health care system.

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